Medical Lib

# CLINICAL MEDICINE

Vol. 31, No. 9 SEPTEMBER, 1924

## *Tomorrow ?*

*TOMORROW I may waxen lie upon my lonely bier,*
*Your smile my closed eyes will not see, your voice my deaf ears hear:*
*I shall not feel the kiss you press upon my cheek or brow.*
*TODAY, all these would mean so much—why not bestow them now?*

*TOMORROW, you may flowers lay upon my new-made mound;*
*Their fragrance will not reach to me, six feet beneath the ground!*
*But, oh! the wondrous words of hope one small red rose would say,*
*If you could find it in your heart, to give it me TODAY!*

C. H. C.

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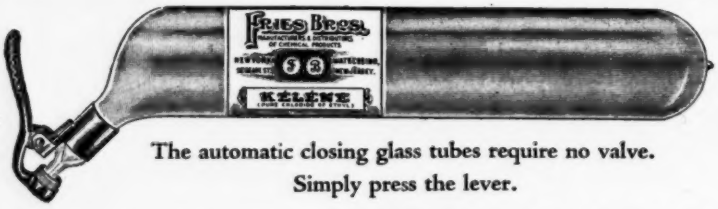


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# CLINICAL MEDICINE

Dependable Therapeutic Fact for Daily Use

Vol. 31, No. 9 September, 1924


## Why Do We Give Drugs?

"THE glands of internal secretion furnish us with drugs of precision, but the giving of them can only help the body in so far as they restore the body to physiological normality and so enable it to produce antibodies, and allow the process involved in their action to take place with efficiency."—W. M. Crofton.

The giving of drugs is, by many, still looked upon in the light of the ancient superstitions which accepted healing substances, administered with appropriate incantations, with childlike and unquestioning faith, taking a curative effect upon the disturbed health of the body for granted. Even now, not only laymen but even physicians consider drugs as "cures" for certain conditions, although these substances can only alter conditions in the animal economy in such a manner as to enable the organism to reëstablish its equilibrium. With very few exceptions, the drugs that are introduced into the organism do not affect the disease directly, although they may exert an immediate effect upon the disease germs. This, perhaps the simplest mode of action, is understood to occur in the case of chemotherapeutic specifics, such as the mercurials and the arsenicals in syphilis, quinine in malaria—and that's about all.

Even in these maladies, it is not the drugs that "cure" the disease: they kill the disease germs (their trepanotropic, etc., action being more marked than the organotropic) before any unfavorable action can involve the cells of the body. Being relieved of the further harmful action of the germs, the body cells can regenerate themselves and the products of disease can be removed—at least to a certain extent. In so far as structural changes have been produced through the influence of the germs, through their irritating action upon the tissue cells, an absolute cure is not possible; the good result will always be relative: the cure will be functional, clinical. The functioning of the organs will be restored with certain reservations, but not to entirely normal conditions.

In view of the fact that, in civilization, there is hardly a body to be found that is absolutely "normal", this relative "cure" of disease may be accepted as satisfactory.

To continue in the treatment of germ-diseases, those for which actually specific remedies are not available, that is, most bacterial diseases, are treated, nevertheless, in a quasi-specific manner; that is to say, by the stimulation of the body's specific resistance against the bacteria in question. If this resistance against the harmful action of certain bacteria has been deficient, so as to permit the disease

to develop, the stimulation of the receptor apparatus, by a suitable bacterial vaccine, will start the elaboration of antibodies that are capable of destroying the bacteria (bactericidal action), of dissolving them (bacteriolytic action) and of neutralizing the toxic substances that they had formed (antitoxic action) either in course of their growth or when their body-substances were disintegrated (endotoxins).

In any event, it is not the injection of the vaccine that cures the disease. It starts the curative process in the body itself. As long ago as over four hundred years before Christ, Hippocrates taught that *natural forces are the healers of disease.* Drugs can arouse these natural forces to activity; they can not accomplish the healing work themselves.

It is often said that an absolutely healthy blood is incompatible with disease and, barring the results of accidents, that is quite true. The organism does not permit any unphysiological ("foreign") substances to circulate in the blood without resistance; it objects to anything that is not in line with its physiological processes. Thus, as soon as disease germs have invaded the body at any place, the blood throws leucocytes around them, tries to surround them with an excluding wall and to carry them away, either to the surface or to the lymph glands or elsewhere, where they may be deposited without doing much injury to the body. The formation of antibodies, mentioned further back, is one step in that process.

Likewise, if a poison is introduced into the circulation, the attempt is made at once to neutralize it; in case of excessive acidity, the alkaline substances are developed and utilized for the purpose, and vice versa. Altogether, an astonishing degree of "teleological" (purposeful—*"zweckmässig"*) provision is manifest in the whole functioning of the animal organism, which must arouse our admiration and reverence.

The endocrines have been mentioned in the beginning of this editorial. It has been shown that these substances constitute the most remarkable "drugs" that have ever been at the service of physicians for benefiting their sick. It is understood that virtually every physiological process stands under the direction of some hormone which gives the impetus, as it were, to its activation. Then the nerve impulse is manifested, appropriate muscular action results, and the process goes on. When the endocrine gland responsible for a certain function is unable to do its work, and when its cooperative glands can not support it, unphysiological results are bound to occur. These are corrected, however, by the introduction of "substitutive" glandular substance of like nature (thyroid for thyroid insufficiency, etc.). The result is that the processes activated through the particular glandular function are made possible; the disabled endocrine gland, or glands, of the organism can rest, and in time will again take up their duties. In so far as a restoration of function is made possible through the introduction of endocrine substances, these drugs are curative. Nevertheless they do not accomplish the actual work, they stimulate the natural forces to carry it out themselves.

In antibacterial treatment, in endocrine treatment, we have seen that the drugs administered stimulate natural, physiological, functions to be reactivated after having become impaired through disease. It may be said that all treatment, medicinal, physical, etc., has the like purpose of restoring physiological function and that disease is treated in that manner and with that purpose. We see the same in digestive and assimilative disturbances. Recent studies have shown that the "purification" and refining of foodstuffs, if carried too far, will remove certain essential substances from them which deprive the body of needed stimulation. The result is, disease which is characterized specifically as *deficiency disease,* and which is counteracted by the deliberate introduction of these essential food factors (vitamines) into the organism. Fresh milk, butter, etc., also cod-liver oil, for instance, contain the fat-soluble vitamine A. Fresh fruits and vegetables, breadstuffs made from correctly-milled grain, carry the vitamines B and C. If foodstuffs are preserved improperly or cured badly, or if they are spoiled in other ways, avitaminosis is the unavoidable result.

Some observations with yeast, which provides two important vitamines, have shown that troubles due to vitamine-deficiency may be combated successfully by the administration of vitamine-bearing substances. It was natural that yeast should be pushed, in consequence, and that yeast-taking became a fad. The argument that the eating of yeast (within reason) was foolish because the necessary food factors may be procured from the food, was not quite justified, because unspoiled food can not always be bought. The manufacturers have seen to it that the processes of utter refining are continued, and the people do not care for the coarser if more wholesome food articles that would be far more useful and

suitable. Therefore, the taking of vitamine-bearing substances may be justified, for an emergency and for certain definite indications. They enable the organism to meet its requirements in vitamines and thus to regulate its metabolic processes.

Like reasoning may be applied to the action of those substances that are commonly designated as drugs. The minerals: iron, arsenic, calcium, sodium and all the rest of them, the vegetable alkaloids like strychnine, colchicine, hyoscyamine, lobeline, etc., etc., all influence the nerves or the endocrine glands in certain ways, through which more normal functions are reestablished and unphysiological processes are remedied. In every instance, it is not the drug or the remedy that produces the cure. The remedy always incites the organism to help itself; which is as it should be.

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**Few things are needed to make a wise man happy; nothing can make a fool content; that is why most men are miserable.—La Rochefoucauld.**

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## ARE THE PEOPLE POOR SPORTS?

It seems to us that the People, as a whole, are very poor sports. For many years, the better elements of the medical profession have attempted to secure adequate legislation through which poorly-equipped and illy-qualified practitioners of all schools of the healing art might be prevented from preying upon the public. It was realized that ignorance and misinformation do not form a good basis for effective health service for the people.

All efforts to secure suitable legislation regulating the medical licensure and medical practice were discountenanced and very often rendered futile by politicians and others who yielded to the persuasive lobbies of irregular practitioners such as the socalled League of Medical Freedom, and of faddists like the antivivisectionists and antivaccinationists. The clamorings of the various "antis", of Christian Scientists, chiropractors and other cultists, made it impossible to get a proper kind of medical-practice legislation passed; in fact, those who desired to bring it about were accused of improper and dishonest motives.

The diploma-mill scandal that was uncovered, a few months ago, in Connecticut, in St. Louis, and elsewhere, is not a new occurrence of its kind; it is merely something that has existed more or less for years but which, finally, became so rank that even the newspapers no longer could stand it. Then, it became excellent copy for newspaper investigations and, as usual, the medical profession was blamed for abuses that it had been trying its best to abolish, these many years. That sinister forces had hindered the accredited agents of the medical profession at every step, on the specious plea of personal liberty, cut no ice. That the people do not want the practice of medicine restricted to those who have acquired adequate qualifications, was ignored. The medical household has to be put in order, and newspaper writers, aided by the deKruifs of all sorts are the Little Gold Dust Twins to do the job.

The dear, stupid People! Does any member of the great public really think that the newspaper writers, the deKruifs and all the rest of the muck-rakers care a hoot for the People? "The-Public-be-damned" is a sentiment by no means obsolete. All these public benefactors have axes of their own to grind, you may be assured.

All this does not mean that these diploma-mill scandals and all those other irregularities and offenses against the public welfare should be condoned or that insufficiently trained and outright ignorant persons should be in a position to practice the healing art, or to claim to practice it, by some absurd method, but always for revenue only. Decent physicians are unanimous in demanding that all abuses in the practice of medicine be remedied. For years, they have pleaded with legislators to be heard and to be permitted to suggest ways and means. They were ignored; or, when any medical man was given an opportunity to be heard, it was usually one who was so far removed from the ranks of the actual medical practitioners that he had long lost touch and had no conception of the real issues involved.

If new laws are required (and they are, to some extent), let the legislators consult leaders selected from among the medical men in the actual practice of medicine as to the kind of laws that would best serve the interests of the public. They need not be afraid that these physicians would consider their own interests or those of the medical profession first. They should realize that the interests of the medical profession are closely allied with those of the public and that, the better the position of physicians is protected, the better they will be able to serve the public.

Let the public treat the honest elements of the medical profession fairly. Let it give them the power to regulate the licensure to the practice of medicine; or let it give them at least an important voice in the matter, and physicians themselves will see to it that abuses

within their ranks are remedied, that dishonest practitioners, ignorant pretenders, and blacklegs generally are amputated from the body professional.

But, the People must be good sports. They must play fair. They have always been dealt with fairly by the medical profession. Let them reciprocate.

**Sweetness of spirit and sunshine is famous for dispelling fears and difficulties; patience is a mighty help to the burden-bearer.—James Hamilton.**

## SHORTAGE OF COUNTRY DOCTORS

*Hygeia* for July discusses an article by Dr. C. C. Cracraft (*Atlantic Medical Journal*) in which the blame for the gradual disappearance of the country doctor is placed upon the country people themselves.

Six reasons why the family doctor will not stay in the country are enumerated by Dr. Cracraft. They are inadequate fees, bad roads, hard work, lack of hospital accommodations, insufficient educational opportunities, and, above all, lack of loyalty on the part of his patients.

The solution is that the country people should pay the doctor adequately and promptly; that they should build good roads; provide sufficient hospital accommodations; make the schools, especially the high schools, what they should be, and, above all, that they should be loyal to the home doctor.

This last is particularly important because the people in the country are anything but loyal to their home doctors, except with regard to the "chores" of the medical practice.

We have cause to entertain the greatest respect for the American country doctor and small-town doctor. He is a type of the efficient, dependable, general practitioner that should not be permitted to die out, for the reason that his disappearance will result greatly to the injury of the people. Yet, it is an unfortunate fact that (with notable exceptions) a great many of the country doctors are those who have failed in the race, or, at least, are running far in the rear.

It is the fault of the people, without a doubt. The people in the country do not support their doctor. They want cheap services, when they consult him at all. And, yet, they pay anything from ten to fifty dollars and more for a consultation in the city, without batting an eyelash. If their own doctor goes away for a week to rest, they are indignant and make him feel it. If the great city doctor travels for three months, they are impressed, and wait patiently for his return. If the country doctor visits the clinics or goes away deliberately for a course of postgraduate study, the wiseacres around the country-store stove sneer at the grown man who still has to go to school, and suggest that he must feel very ignorant. If his city colleague goes to Europe for a year's "research", the country people take the announcement at its face value, knowing but little that this year of research often is a euphemistic excuse for a prolonged good time. It is a strange thing, and the saddest part of it is, that the people are bound to suffer because of their own stupidity.

**True gladness doth not always speak; joy, bred and born in the tongue, is weak.—Ben Jonson**

## PSYCHIC CAUSES OF MUCOUS COLITIS

According to Charles G. Stockton, who contributes the chapter on Diseases of the Intestine to "The Oxford Medicine" (Vol. III. 1921), two factors that stand out conspicuously as related to mucous colitis are, spastic constipation and enteroptosis. In many textbooks on Medicine, no causes are given. Osler ("Practice"), however, says that true mucous colitis, a secretion neurosis of the large intestine, is met with particularly in nervous and hysterical patients; and, according to Boardman Reed ("Diseases of Stomach and Intestines"), in most if not all instances, the patients are hysteric or neurasthenic, and the nervous constitution is a strongly predisposing cause. It is this latter etiologic factor that interests us in connection with an article found in the *Deutsche Medizinische Wochenschrift* (May 2, 1924, page 576).

Walter Jehn reports the case of a young woman, 27 years old, who was neuropathic and inclined to vasomotor disturbances. There was a slight hyperthyroidism. While still weak, after an intestinal affection which was supposed to be typhoid fever, the patient suffered a severe psychic shock through the breaking of her secret engagement, for which mental relaxation was impossible because she had no one to whom she could talk about it. After that, there followed obstipation, chronic fatigue, want of appetite; intestinal symptoms persisted. Gradually, the manifestations of an anxiety state became evident and a definite mucous colitis developed. The customary treatment, with gentle laxatives, low and high enemas, etc., remained without result. It was only when the attending physician came to sus-

pect a possible psychic factor in the condition of the patient, and directed his inquiries accordingly, that he found the casual connection. Hypnotic treatment (second grade) gradually controlled the affection and the patient was discharged relieved from her trouble. She can stand heavy work (night nursing) and is in splendid health.

Come to think of it, all the cases of mucous colitis that have come to our attention were in women and all the patients were exceedingly "nervous," in fact, neurotic. The attacks of the colitis would come on periodically, and we assume now, very naturally, that these attacks were usually associated with some psychic disturbance or other. We confess to having overlooked this factor; probably because we have gotten out of the habit of consulting Osler's "Practice" as constantly as we used to do. After all, despite our difference of opinion, as regards treatment, "Osler" is a mighty good old stand-by.

In view of the possible psychic etiology of mucous colitis, we shall think, on a future occasion, of the very persuasive asafetida combined with valerian. One may also resort to relaxants like hyoscyamine and, possibly, emetine. The pain would in all probability have been treated, by the old practitioners, with opium, in the form of the tincture. However, it will be controlled well by the hyoscyamine. While Van Noorden places the principal emphasis on the treatment of the obstipation and on the dietetic management of these cases, it appears to us reasonable to consider the nervous or the psychic factors, if these are present. If they are once controlled, it will be far more feasible to combat the physical irregularities that still persist.

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**Life, to be worthy of a rational being, must be always in progression; we must always purpose to do more or better than in time past.—Johnson.**

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## CHEMICAL PURITY

The expression "Chemically Pure", abbreviated "C.P.", carries a more or less indistinct meaning to us of the medical profession. To the chemist, "C.P." goes so far as to insist that utensils be cleaned with boiling nitric acid, which may be compared with the requirement that, in preparing medicines, ampules or solutions shall be rendered clean by fractional sterilization, using dry heat or boiling water.

In the preparation of foods, the standards are quite different. For instance, the miller separates the bran from the flour with the sole object of improving its color, ignoring entirely the necessity, from the standpoint of food value, of retaining those elements removed by the bolter. This demand for the fictitious standard of absolutely white flour goes so far as to institute bleaching methods which add nothing whatever to the nutriment of the bread made from it.

This common practice has led to the manipulation of the separated bran, making it palatable and effective in supplying the animal economy with needed elements, otherwise discarded.

Another example of the foolishness of the extreme in purity is seen in the use of distilled water for drinking purposes. For intravenous medication, as, for instance, the administration of neoarsphenamine, we find it desirable and necessary for safety to use a triple distilled water prepared in a special all-glass still and packaged in non-soluble flint-glass ampules. But, for drinking purposes, a less degree of care is exercised, and it must be remembered that even ordinary, distilled water is devoid of these soluble mineral substances necessary to normal nutrition. For this reason, a pure, bacteria-free, spring water is preferable where it can be had. This is available in such small quantities for our cities, and so impossible for tourists, sportsmen and travelers to secure that the use of a chemical sterilizer, such as halazone, is the only practical method to insure absence of dangerous microorganisms. It would be well not only to use halazone ourselves but also to insist that our patients learn to depend on it when traveling. A word of explanation by you is perfectly in order, calling attention to the danger of typhoid fever in untreated water, and the safety secured by the use of halazone.

Not all states are as careful of their water supply as Illinois; and, yet, its Department of Public Health reports condemnation of 46 percent of 2830 water supplies examined. These included water from all kinds of dug, drilled and driven wells, springs and water derived from distillation systems.

"Safety first" demands the use of a potable water, but not that extreme chemical purity demanded by intravenous medication, nor that confidence in a water just because it looks clear and is without odor.

Another example of the foolishness of the extreme is seen in current advertising of certain table salts. Here, the manufacturer, like the flour miller, demands the artificial requirement of absolute whiteness, overlooking

the need of the economy for those very elements he removes.

It is these other elements, notably iodine, that therefore must be supplied in other forms just as the food purveyors have developed a palatable bran.

The importance of the iodine in table salt is recognized by at least one state (Michigan) which demands, by statute, that only salt containing iodine may be sold in the state. The serious drawback of the absence of iodine is easily demonstrated by the incidence of noticeable and hidden goiter not only in girls but in boys also.

Until table salt containing iodine is generally available, it is our duty to insist that iodine be used in some preferably palatable form. It is an interesting experiment in applied therapeutics to exhibit a daily dose of iodine, with or without tape-measure records, and actually watch the gradual subsidence of the enlarged thyroid. More than that; it is our duty along lines of preventive medicine to insist that our young people in "the goiter belt" rigorously follow the prescribed iodine medication, which alone will prevent those horrible and dangerous deformities all too frequently seen now.

If, as has been said, a case of typhoid fever indicates that someone has committed the crime of failure to disinfect the typhoid stool, it certainly follows that failure to properly employ iodine is equally a crime when this neglect is the basic cause of the increasing number of goitrous patients.

In this practical age, we should demand practical purity as determined by the requirements of the situation: whole wheat flour, potable water, and table salt containing iodine. Until these are at hand, we must supply those needed elements, including as well the phosphates and other necessary substances in suitable form.

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**We see how much a man has, and therefore we envy him; did we see how little he enjoys, we would rather pity him.—Seed.**

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## "THE VALUE OF BACTERINS IN PRACTICE"

On p. 612 of this issue of CLINICAL MEDICINE, we print an article on the value of bacterins in practice.

The author calls attention to the fact that vaccines do not always stay the disease and cure the sufferer. It would seem unnecessary to make this statement, but it is evident that he has heard the remark that vaccine therapy acts well in some cases, even brilliantly at times, but not in all cases.

That too much has been expected of vaccine therapy seems evident. This over-expectation is, no doubt, due to a lack of more thorough understanding of the subject and to some extravagant claims that have been made from time to time.

The author says we must remember that, in dealing with immunizing forces, there are complex phases that interfere with favorable results. His experience with vaccine therapy has evidently brought out the sound reasoning that vaccines *alone* can not be depended upon in all cases.

This calls to mind the fact that, when all the functions other than the immunizing processes are working properly, we will get better results from the use of vaccine. The suggestion for the use of vaccines as a prophylactic measure in surgery at least calls for serious consideration and a very thorough trial. Extensive clinical experience by careful observers may bring out some valuable information to surgeons. Postoperative infections do occur following the most careful aseptic technic.

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**Every person has two educations—one which he receives from others, and one more important, which he gives himself.**

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## CHRONIC FATIGUE INTOXICATION

Recently, a little book was sent to us for review which contains so many lessons for daily utilization that we prefer to discuss it in the editorial pages rather than in the review department. We refer to Dr. Edward H. Ochsner's book on the subject cited in the title of this editorial article, which bears the subtitle: "A Heretofore Inadequately Described Affection." Evidently, Doctor Ochsner views his chronic fatigue intoxication in the light of a separate clinical entity which has an etiology, pathology, symptomatology and treatment of its own. Perhaps he is right. At any rate, the book is mighty interesting.

Chronic fatigue intoxication, according to the author, is a general, chronic, organic, systemic disorder, the result of the gradual accumulation in the tissues of excessive amounts of fatigue material. It manifests itself symptomatically in a deviation from the normal of practically every function of the body, in that reaction is out of proportion to the stimulus

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For the announcement of this book, see page 666 in the "Among the Books" department of this issue of CLINICAL MEDICINE.

acting, by more or less generalized tonic muscular spasm, by an inability on the part of the affected individual to secure physical relaxation or mental repose, and by a characteristic group of physical signs and symptoms.

These symptoms are in part general; they affect the skin and appendages, also the subcutaneous areolar tissue, the muscular system, the joints. There are gastrointestinal, genitourinary, respiratory, circulatory symptoms, and nervous symptoms. The affliction is subject to exacerbations and is more prone to occur in the third and later decades of life than in the two earlier ones. Referring to the great variety and multiplicity of symptoms, which the author enumerates, he remarks that the same symptoms may be observed in a great number and variety of other diseases. So, also, lues can, and occasionally actually does, symptomatically simulate practically every other known disease, so that this fact, by itself, need not cause anyone to doubt the actuality of the symptom complex described. As a matter of fact, chronic fatigue intoxication is, if anything, even more protean in its manifestations than is syphilis, and virtually every normal physiological function may be altered.

As for the etiology of chronic fatigue intoxication, Ochsner refers it most emphatically to physical overwork or overstress continued for a considerable period of time, and which produces waste more rapidly and far in excess of the power of elimination. Each individual has a certain speed and a certain capacity for work at which speed and capacity he can accomplish the most with the least tear on his system. If he exceeds this speed of stress for any considerable length of time, he is almost sure to develop this condition. Of course, the speed and capacity vary with the individual, according to his endurance and personal resistance.

A specially fruitful source for trouble is found in overwork shortly after a severe illness such as typhoid fever, septic infection, puerperal sepsis, arthritis, also continued exposure to befouled, vitiated air in ill-ventilated, overcrowded workshops and living apartments; exposure to coal-gas and sewer-gas. Long-continued loss of sleep also is an important factor, as are excesses of all kinds, exposure to extremes of heat or cold, etc.

Concerning the role played by mental overwork, the author suggests that this is difficult to determine inasmuch as this is usually associated with eyestrain—which is physical overwork. To be sure, mental overwork and emotional overstimulation are often contributory causes; but the author is doubtful as to whether either one alone or both combined are ever able to produce chronic fatigue intoxication.

[We are reminded of an article, entitled "Fatigue — Endocrine Weariness," by John McNulty and published in the *New York Medical Journal* for February 12, 1921, in which fatigue is called a symptom of exhaustion of the autoprotective mechanism. Our late friend, George F. Butler, attributed fatigue—in his last book, "How the Mind Cures," New York, 1921—in part to the doing of distasteful work. We must confess that mental and emotional overstrain seem to us to be very fruitful sources of fatigue-intoxication which may manifest themselves in serious and obstinate physical ailments, such as mucous colitis.—ED.]

Some of the types of persons most commonly afflicted are enumerated in order to illustrate the causes which produce the condition; thus:

1. Very conscientious and especially brilliant professional men.
2. Brilliant business men who work hard all day, eat much and rich food, attend functions in the evening and do not sleep enough.
3. Debutantes who are constantly on the go, eat foolishly, dance excessively in stuffy rooms and clothed unhygienically.
4. Ambitious college students of moderate means who have to do outside work in addition to their studies.
5. Farm boys who are often overworked during adolescence.
6. Manual laborers and farmers.
7. Pace-makers in industrial plants and their less efficient fellows who try to keep up with them.
8. Individuals with uncorrected errors of accommodation.
9. Physical handicaps that place the individual at a disadvantage with his competitors.
10. Business and professional women who try to fill the two positions of bread-winner and home-maker.
11. The willing assistant of a chief who has an excess of work piled on him, partly because of the inefficiency of the chief.
12. The overconscientious, private-duty nurse.
13. The institutional nurse, and the superintendent of nurses.
14. The overconscientious mother, especially the farmer's wife.

Speaking of the pathology of chronic fatigue intoxication, Ochsner mentions changes in

blood and blood vessels; deposits in subcutaneous areolar tissues and tendons; peculiar thickening of the skin; trophic disturbances of the skin and its appendages and other structures; thickening of periarticular tissues; thickening of nerve trunks; the always present muscle spasm; the demonstrable relation between the various deposits and the symptoms.

For details regarding all topics referred to in the foregoing, also relating to animal experiments, to diagnosis, prognosis, prophylaxis, the original must be read; in fact, it should be read by all means, because the condition described is one that is sufficiently frequent and is too often not recognized; hence, ill-treated to the disadvantage and disappointment of patient, family, and physician.

In the treatment of patients suffering from this affection, Ochsner says, four objects must constantly be kept in mind:

1. Maintain or improve the nutrition of the patient as the individual case may demand;
2. Prevent the further accumulation of fatigue material;
3. Ameliorate the symptoms as much as possible;
4. Remove the already accumulated fatigue material.

With this succinct outline of the treatment, we are content to leave the rest to the discerning reader. We believe that we have said enough to convince him that he will do well to look into this malady which, undoubtedly, claims a great many victims that might be restored to health if studied carefully and treated wisely.

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**As a soil, however rich it may be, can not be productive without culture, so the mind without cultivation can never produce good fruit.—Seneca.**

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## THE REAL AUTHORITY IN MEDICAL PRACTICE

Attached to the army, there is an intelligence department which is charged with the duty of obtaining information on any special point that the commanding officers may desire. I do not know whether the intelligence department ever makes recommendations; but, if it does, these recommendations are subject to approval by the officers in actual field service, or at least by officers who have seen active service.

It may be invidious to argue by analogy. However, in some ways, the medical profession is composed of various corps, each with its leaders. It must be admitted that these leaders do not find the unreasoning obedience that is accorded to the orders of commanding officers in the army. And, that is fortunate for the sick, because it may conceivably happen that the "officer" is at fault in his orders and that the "private" knows his business very well. Aside from the actual fighting corps, in the field of medicine, there are theoretical corps making up the intelligence department. They are recruited largely by the laboratory men, the research men, the academical investigators and then the desk-clinicians who never have had patients of their own and should express opinions only very modestly, because these views can at best be only theoretical and do not have the support of practical experience.

In our warfare against disease, new arms are often proposed. These may be offered because supported by practical, clinical, experience and observation; they may be the products of laboratory research and may have no other proof than that seen in experimental animals. In any case, the merits of any remedy that is offered as effective against disease can be determined and established only in the practical bed-side experience, in actual practice. The experimental observations may afford guidance and suggestions; they can not determine the definite merits or demerits of any method of treatment. In the words of the learned editor of *Therapeutic Gazette:* ". . . when a remedy has been found therapeutically active and is tested in the laboratory upon an animal in an experiment and proved useless, it does not necessarily follow that the original observation at the bed-side is inaccurate." In fact, we might add, it is quite conceivable that the experiment was improperly arranged, inaccurately carried out, incorrectly interpreted and is altogether valueless for any practical purposes. Such things have happened.

Moreover, if we read in a reputable medical journal, in an article contributed by a great scientist, that "the outcome of an experiment is always more or less dependent upon the good-will of the experimentor" . . . we are taken aback somewhat and hesitate to accord to experimental proof quite the value that is claimed for it.

For years, in fact, almost during the entire professional life-time of many medical men now in practice, the laboratory man has arrogated to himself the last word, the final decision on many questions that concern him but indirectly. He has presumed to decide upon the value, or want of value, of many remedial agencies in cases that he simply

does not understand. In fact, the contrast between the laboratory man and the medical practitioner has often become acute and the latter has rightly resented the slights put upon him by the "intelligence officers" who claimed to have authority to which they were not entitled.

"The trouble with men trained exclusively in laboratories," said the late Dr. Meltzer, "is twofold: First, they do not seem to see that a medical fact, observed critically by a capable physician, deserves as much credence and consideration as a fact developed by laboratory methods; and, second, the laboratory man offers positive opinions in a field in which he has no experience." Exactly. It is only too true that, "as medicine has become more scientific, it has become more humble. The sacerdotal dogmatism which used to prevail among doctors has now been banished from the ward and has found a refuge in that very modern shrine, the laboratory. . . ." (*Brit. Med. Jour,* 1913, I p. 1235.) So erudite an investigator as the late Eugen Albrecht once declared that the results of animal experimentation are valid only in so far as they correspond with the established results of human pathological anatomy. Where they differ, the result of the animal experiment is irrelevant.

All this being true, to the best of our knowledge, we submit it as a self-evident fact that a very important factor in the economy of the medical profession is the humble general practitioner, who does the chores of medical practice, who usually does not make great pretenses for possessing wonderful erudition who is quite willing to let others tell him what they found and observed, and what they concluded from their experimentations—but who justly claims the right to make his own ultimate decision, based upon his own observations in his own patients, as to whether a certain remedy or method possesses practical merits or whether it is of no value at all. The general practitioner resents being told, without an opportunity for a come-back, that such and such a remedy is proper for him to use and that the other one is all but *verboten,* that its employment will brand him as a charlatan. Yet, such impertinence has often been offered to the general practitioner.

We do not decry the value of experiments; we do not deny that the "general officers" of the army of medical practitioners, the professors, the clinicians in the great hospitals, etc., etc., have wonderful opportunities for observation and that their advice is of great value and worth having. However, we submit that the circumstances under which these great men see their "clinical material" are just as different, in many ways, from the conditions that Doctor Main Street and Doctor Cross Roads have to deal with, as the conditions obtaining in the animal houses of the laboratories. The patients who are "just folks" are not experiment animals, nor are they "clinical material." They are folks, and don't you forget it! They want to be treated individually and personally and on the merits of their own personal feelings and aches and pains, and they want their own doctor to do it. The personal factor is active here, which is in abeyance entirely in the laboratory as well as in the clinic.

Therefore, the results of observations made at the bed-side of "personal" patients very often are of far greater value than are those rubber-stamp decisions that are handed down often enough from the founts of wisdom. After all, it is the general practitioner, the one who comes nearest and closest to the patient, who has the best opportunity for deciding what is of use in human practice.

He may be mistaken; true. He may mistake a "purely psychic" result for one due to a remedy under consideration. If we could find a remedy that were sure to exert constantly a definitely curative "psychic" effect, it would be worth much, both to physician and patient. Unfortunately, this is a factor that is difficult to evaluate. Nevertheless, we can not bring ourselves to become hysterical about the fact that, in a percentage of cases, the effect must be designated as "purely psychical." Does it not happen very often that diseases, that are very physical indeed, are nevertheless based upon etiologic factors that are "purely psychical"? (See, for instance, the cases referred to in the editorial appearing on page 596 of this issue of CLINICAL MEDICINE.) That being the case, the physical conditions require psychical treatment and are usually found to resist physical measures that are unsupported by psychical influences.

But, what we were going to say, the point that is in our mind is, that the final authority in deciding upon the practical merits of any particular form of treatment is—not Professor Hospital Clinic, not Doctor Laboratory Technic, not their colleague, the incumbent of the chair of physiology, but it rests with Doctor Main Street and Doctor Cross Roads and with their humble brethren. You may be quite sure that, ultimately, no useless, undeserving remedy or method will be able to

prevail. Even though the "practical" men may be carried astray by faulty impressions, though they may follow fads, in the end, their judgment is sound. And, come to think of it, are the "intelligence officers" of the army medical quite free from fads and imaginings? We have cause to say: They are not.

Therefore, we of the ranks, the buck privates, may take heart and remember that, in life as in the army, it is the privates who do the actual fighting. The officers point the way and give counsel as to means. The work falls to the men in the ranks. Therefore, my fellow privates, we are proud to be in the ranks. Don't we do the biggest part of the work, and does it not accomplish the most actual good? We do and it does.

We venture to say that the proportion of errors of judgment made at the bed-side compares favorably with those committed in the laboratory.

As you may guess, we are all for the general practitioner. He claims and should have the last and final decision on the merits of remedies, not the man who has watched their effects on guinea pigs and mice. It is the general practitioner who bears the brunt of medical work; it is he who has the best opportunity to see conditions as they are. Manifestly, it is he who can best decide, comparing laboratory results with his own, on what is right.

**A thought embodied and embrained in fit words walks the earth a living being.—Whipple.**

## GLIOMA OF THE OPTIC NERVE

We invite the attention of our readers to an able contribution on this rare, yet highly interesting, disease, from the pen of Dr. Henry R. Lesser, published as an original article in this issue (p. 629).

Doctor Lesser is the same gentleman who was mentioned by our Doctor Blech in his "Memoirs of the World War." Before the war he enjoyed a lucrative practice as an oculist in New York City. During the war he served at the front and eventually was chief of the opthalmologic service of Base Hospital 208.

After the war he settled, for family reasons, in Toledo, Ohio.

The case published is a great credit to Doctor Lesser, not only because it shows the diagnostic ability of the author but because he succeeded in removing the eye with the tumor attached to the optic nerve through a conjunctival incision.

The pathologic report confirms the original diagnosis.

Although the condition is rare and of special interest to opthalmologists rather than to general practitioners, the article should be read with great care; for, the symptomatology may lead, if seen by the non-specialist, to an early diagnosis and rational therapy in time when a disaster can be averted.

## AN AID IN PUERPERAL INFECTION

It has been asserted that success in the treatment of puerperal infection depends mostly upon obtaining an increase of leucocytes in the circulation of the person infected.

One of the best remedies for the purpose—one more often used in France than in our own country—is sodium nucleinate. This is given intramuscularly.

Sodium nucleinate has a wide utility range. For the purpose of increasing the number of leucocytes in the blood, it appears to be indicated in fevers, septic anemias, sluggish ulcerations and other conditions, in which the resistance forces of the body are clearly unable to cope with the infection.

# Leading Articles

## Work of Louisiana Physicians Who Have Made History

By Dr. and Mrs. GEO. H. TICHENOR, Jr., New Orleans, La.
Members of Kentucky State Historical Society and Louisiana State Historical Society.

### Object

THE object in writing this article is, to refute recent propaganda in regard to Louisiana's school system, to correct an erroneous impression in regard to social conditions existing at present in the state of Louisiana, to give for the first time a meager outline of her medical history and the work of some physicians which has affected medicine nationally and internationally. In view of the rapidly expanding trade relations and development of this section of our country, which is of especial interest to the states bordering on the Mississippi River and in industrial centers like Chicago, CLINICAL MEDICINE has been selected for this publication.

### Difference Between History and Propaganda

The World War developed as never before the propaganda industry which has been applied since for every conceivable purpose.

There is a vast difference between history and propaganda. History is a narration of facts with a view of teaching future generations why progress or decay occurred in the past, so that these future generations may profit thereby; propaganda is related distortion of facts with a selfish view of benefiting a few to the detriment of the world at large.

### Social Progress Dependent Upon the Physicians' Comprehension of Medical History

Every man has become more and more "his brother's keeper" as civilization has advanced. Especially is this true in regard to medicine. The radio, the flying-machine and other modern inventions have made the world neighbors and the wheels of commerce are stopped only where revolution and disease interfere. The doctor will, as progress continues, be more and more called upon to apply his scientific knowledge, not only to warfare but to racial and industrial questions; therefore, an intelligent comprehension of the history of society, especially medical history, is absolutely necessary for the success of the active practitioner of medicine.

Lately, there has been a number of writers and industrialists who are telling the public that "history is bunk"—it is very damaging "bunk," sometimes, to certain selfish interests. While a few of us are able to carry out original research, we are not lacking in "horse sense" when facts are presented.

We are living in a fast age and it is essential that we should know what has been generally accepted as scientific truth without delving into hundreds of volumes of medical literature to get a grain of truth; volumes dealing with individual theories which time has proven fallacious and big-city health reports not adapted to modern social conditions. We revise our pharmacopœia, but let the medical student flounder about in the sea of medical literature without raft or compass.

Like all other modern organizations, medicine has been organized, centralized and bossed. Quackery within the organization consists largely in medical politicians obtaining medical and political offices and using them to impress the public through the press or by religious prestige of their medical superiority and of what they are doing or have done for science.

It is the object of this article to state specifically what each regular, licensed physician has actually done to aid human progress.

If I neglect mentioning the achievements of any physician, it is not due to malice, but to lack of knowledge. I will appreciate any additional information given that may aid me in this important pioneer work, as I believe in "rendering unto Cæsar the things which are Cæsar's", whether friend or foe. I believe, too, that it is not only common justice but also an incentive for achievement in medicine, for the historian to relate the achievements of our forefathers in medicine.

The future historian is going to relate more and more the acts of men who have done

those things that have caused real progress and happiness, rather than the actions of rulers and the success or failure of soldiers. I find very little encouragement given in the medical press along these lines except in the following quotation:

**American Medical History Clubs**

Medical History Club, *Jour. A. M. A.*, July 1, 1911.

"A favorite statement of continental European writers is to the effect that the average English and American physician is often lacking in a proper interest in the history of his subject, the reason usually assigned being the intensely practical nature of the English-speaking practitioner, which allows him neither the time nor the inclination to approach his specialty from the historical side. While much of the best historical work in the past has undoubtedly been done by French and German scholars, like Littré and Daremberg, Chouland or Pagel, yet such exhaustive recent monographs as those of Adams, Greenhill, Payne, Norman Moore, D'Arcy Power, Osler, Sir Clifford Allbut, Finlayson, Billings or Weir Mitchell have gone far to lift the imputation of late years. For the practitioner who writes, the advantage of a proper study of 'origins' is, of course, self-evident. Much superfluous controversy, much waste of the writer's (and reader's) time and of a journal's space might be saved if physicians investigating a subject always knew exactly what others had done before them.

"A proper interest in the historical side of medicine might easily be stimulated by means of short courses in medical history for students before graduation or by the formation of medical-history clubs among practitioners themselves. As such club members are usually made up of kindred spirits, the membership of any is not likely to be too large, which has the double advantage of giving every one a frequent chance to read papers and of avoiding unnecessary repetition in discussions. As an example of what can be accomplished in this field, we may instance the remarkable work of the Historical Club of the Johns Hopkins Hospital, which was organized in November, 1890, beginning with exhibitions of rare medical classics by Drs. Billings, Osler, Kelly and others, and which has since turned out so many fine papers published in the *Bulletin of the Johns Hopkins Hospital.*

"Another prominent medical-history club, the Charaka Club of New York City, organized in 1898, consists of eighteen members and has already published three handsome volumes of transactions, which have been reviewed in these columns. Among the subjects treated were 'Greek Medical Fees', 'The Evil Spoken of Physicians', 'The Cult of Æsculapius', 'Antonius Musa', 'Fracastorius', 'Shakespeare's Last Illness', 'The King's Touch for Scrofula', 'Dutch Physicians in New Amsterdam', 'Garth's Dispensary' and 'Flauberts' Epilepsy'; and the proceedings have been enlivened by original poems, little plays, novelettes and facetiæ by the different members.

"The Medical History Club of Washington, D. C., was founded in 1908, and prints its transactions in the *Old Dominion Medical Journal.* Durng the present year, interesting papers on Auenbrugger, Pasteur and Bichat and 'Casserius and Anatomic Illustration' were read. Practitioners of the town and country will find relaxation from the career of their busy lives in little coteries of this kind and their papers will lend variety and interest to the journals and transactions of their respective medical organizations."

The JOURNAL failed to mention, however, the Western Association for the Preservation of Medical Records, Cincinnati, Ohio.

Dr. Otto Jüttner, of Cincinnati, Ohio, wrote me, October 12, 1909, after reading my article on Dr. William Walker, lawyer, physician and filibuster, who sojourned in New Orleans for a while, suggesting that I undertake the collection of a complete medical history of New Orleans, etc. His letter and the interest shown by the publication of this biographic sketch by CLINICAL MEDICINE led to the collection of data which are now contained in this series.

**Historical Archives**

Unfortunately, Louisiana has, at present, no large State Department of History and Archives similar to Mississippi, Alabama, Wisconsin and other states. In the Cabildo, there is a historic collection. Most of the work in Louisiana has been an individual rather than an organized effort; however, Louisiana has produced two writers of more than local repute, Charles Gayarré and Alcié Fortier, the latter having been a former teacher of the writer's. The Louisiana Historical Society is composed of a number of distinguished gentlemen who have contributed valuable papers, but we are lacking a regular State Department such as Mississippi possesses.

It is evident to any research worker that the archives of Louisiana must have been removed to Spain and France when their governments relinquished control over Louisiana territory. This fact is substantiated by investigators who have dwelt upon the rich stores of material bearing upon Louisiana history, to be found in the archives of London, Paris, Madrid and other places. Let us hope that, some day, the Government will undertake to have them transcribed. Louisiana Confederate military history was copied from the records in Washington and my father, Dr. G. H. Tichenor, Sr., was one of the prime movers in appointing a custodian and having the legislature appropriate funds for this purpose. Tulane Louisiana State University, the State Normal at Natchitoches and other institutions

have splendid courses and libraries, and the library of the Louisiana State Medical Society offers abundant material for historical work, together with excellent museums. Some of the club women, notably those of Shreveport, Ruston, Monroe and Natchitoches have carried out systematic programs in investigation of productive industry with local or State history as themes. Mr. John T. Michel, former Secretary of State, incorporated in his reports much that was important and of value to the student of our state history. Dr. Joseph Jones has a historical sketch regarding the State Insane Asylum in his memoirs. Miss Grace King, Prof. Ficklin, a former teacher of mine, Prof. Henry E. Chambers, W. O. Hart, and my friend Edward A. Parsons, at present Vice-President of the Louisiana Historical Society, have all done their share of valuable work for Louisiana history.

Louisiana's geographical location, the heart of the United States with the mighty river, the Mississippi, renders it necessarily, with possibly the exception of Virginia and Massachusetts, the most important state as to history and supreme in interest for the fact that its territory has been under Spanish, French, American and Confederate flags—to say nothing of the reconstruction period, probably the most exciting of any in the Union.

Even now, notwithstanding New Orleans' boom, it retains a great deal of its ancient and quaint features. Jackson Square, the old *Place d'Armes,* the scene of so much history and romance in French and Spanish times. The queer three-story buildings with which two sides of the square are enclosed were built more than a hundred years ago by the Baroness Pontablo, daughter of Don Andres Almonastrey Roxas, a rich hidalgo, who was commandant in Spanish times, and made a fortune in the silver mines of Mexico. He built a larger Charity Hospital, a Town Hall, and the Cathedral, which was pulled down to make way for the present one. Don Andres Almonastrey received from the town, in 1770, the large space of ground on St. Peter's and St. Ann's Streets, on perpetual yearly rent. His remains lie buried under the Cathedral pavement, near the altar, where his name may be seen cut into the stone. Chimes, at stated times, are rung in honor of his memory on the Cathedral bells.

It is evident that the Charity Hospital was started as a private hospital. There are no authentic records of the early French and Spanish hospital; probably they were removed with other archives to their respective foreign governments. Its career as a private institution continued from 1779 to 1811, when it was given to the city and, in 1880, it became a state hospital and has remained so ever since. It is interesting to note, as it throws light on the habits and customs of the times, that from 1830 to 1840 this hospital was supported by a tax derived from gambling houses, which has been said to have been ample for the purpose. A change in methods of tax collection occurred in 1846 to 1847, when the legislature levied a tax of two dollars on all immigrants from foreign countries landing from vessels at the port of New Orleans. Evidently this was the chosen gateway of a great many to enter the States.

Up until 1848, there does not seem to have been any very great classification of diseases in regard to separation. According to Charles Gayarré, historian, "I have always understood that, before the existence of the insane asylum at Jackson, demented persons who, before 1848, were not numerous, used to be taken care of at home by their own families, when this could be done. Otherwise, these unfortunate beings were sent to the Charity Hospital, where, if I am not greatly in error, there was a part of the building appropriated for them." (Letter to Dr. Joseph Jones, May 8, 1889.) It is interesting to the physician that the insane were not numerous before immigration became heavy, and the population was homogeneous and not mixed as today, with our increasing insanity.

### Colonial Medicine

It is easy to surmise what the status of medicine was in the early colonial days, from the accounts of the countries from which the colonists came. The ships brought over contract physicians. Strange to say, this system has never been abolished in Louisiana. Even up to the present day, we have benevolent associations that hire doctors by the year for a few cents a month, furnishing medicine and sick benefits to its members. Specialism then, as now, referred to special ability along certain lines rather than following a specialty exclusively in regard to treating the sick. Today, an eminent surgeon is frequently mention, by the press, as having been in attendance on the late Mr. Money Bags, who died of malaria, etc. From the early suits brought by the doctors there, for services, as recorded in the court records, they had just as difficult a time in being remunerated as now.

### Napoleon's Surgeons

There is no doubt but that the surgeons who came to Louisiana from France and who

had served under Napoleon laid the first stones in the foundation of Louisiana medicine of today. I have been told, by some of their descendants, of their skill and success in surgery. I heard Dr. Ernest Lewis, Professor of Obstetrics, etc., of Tulane Medical College, state in a lecture that he is satisfied that the first hysterectomy performed in the United States was done by one of Napoleon's surgeons in Louisiana; but, unfortunately he can not remember his name. When a student, I have heard Dr. Sanford Chaille, former Dean of the Tulane Medical College, tell how bodies were stolen from the old St. Louis cemetery by members of the French Medical Society for the purpose of holding autopsies and describing the difficulties under which they were obtained. Let us remember that, when Napoleon saw how theoretical his surgeons were as the result of the European religious dogma that we must not investigate the working causes of nature, he made hospital experience a necessary qualification for medical licensure which, of course, affected Louisiana colonists. From Colonial days up to date, it has been the pride of the medical department of Tulane to boast of the advantages offered in the way of clinical material and surgical advantages.

The Louisiana colonial period added to medicine the experience of Napoleon's armies and the therapeutic action of a number of native herbs known to the Indians in this section.

Let us remember that, when the nineteenth century dawned, European medicine was investigating the practice of vaccination. Acute diseases were thought to be caused by exposure to cold. Blood-letting, starvation, mercury, antimony and opium were the "standbys" of therapeutics. Gross anatomy was hampered by scarcity of material; histology was just being studied; physiology was a speculative affair; pathology was an affair of sane suggestion; diagnosis was made solely on subjective symptoms, and the treatment of disease was carried out in accordance with dogmatic traditions.

Syme and Chopart, however, were beginning to show the public that an operation did not mean a death certificate and the startling things they accomplished started medical progress in a period of apparent stagnation as regards medicine. They were what may be termed conservative surgeons.

### Difficulties Louisiana Physicians Have Had to Overcome

There is no class of men deserving more praise for their heroic struggles in advancing civilization and education especially than Louisiana physicians. Their triumphs over the physical condition of the low-lying terrain, their victories over malaria and yellow fever and other climatic diseases stand as records surpassed by no other people and equalled by few, if any.

The diversity in the origin and nationalities of the white population, the existence in nearly equal numbers of whites and negroes, the problem of miscegenation, the deep-seated hatreds racially and nationally imported, the irreconcilable differences of religious beliefs and European and South- and Central American habits and customs present problems that the wisest would hesitate in attacking.

It is no wonder that the ideal as regards charity differs from the American comprehension of the problem. Article 167, July 23, 1879, recognizing in the State Constitution the lottery as a means of supporting charitable institutions, hospitals, and common schools, unfortunately, lasted a whole generation before it was finally abolished.

"Storyville", a section of the City of New Orleans, named after a councilman who drafted the ordinance permitting prostitution within a certain section, was not abolished until the beginning of the World War. I wrote in favor of abolishing it in the *Masonic Journal, Square and Compass,* and there was much opposition. The lives in this section were beyond description and the imagination to which human degradation can be carried.

This brief summary of conditions gives a faint idea of what the practicing physician had to combat in regard to physical conditions and the public. But the worst is yet to be told. During the years 1853, 1854, and 1855, New Orleans alone lost 12,780 of her citizens by yellow fever and, in 1878, she lost 4,056 citizens and about $15,000,000. These epidemics and the constant overflows and inundations of the lands adjoining the Mississippi River added to the problems already mentioned.

It is natural, from the early colonial times, that even the public should advance theories as to the causes of these epidemics and that literature should be abundant on these subjects. Wm. Darby, Louisiana's first American historian, says in his history that the people always looked for an epidemic when mosquitoes became plentiful and annoying.

### Louisiana's Important Medical Acts

It was not until 1894 that Louisiana attempted to adopt a standard of education. It

was then enacted that the State have two Boards of Medical Examiners appointed by the Governor—one of five physicians recommended by the Louisiana State Medical Society and one of five physicians recommended by the Hahnemann State Medical Society. It required that they must be graduates in medicine and three of them were declared as being sufficient to conduct an examination. Only holders of a diploma from a medical college in good standing, as determined by the board, were entitled to be examined.

This act, together with the act made in March, 1855, "to establish quarantine for the protection of the state," marks the beginnings of systematic medicine in Louisiana. The legislature, of 1877, which superseded the radical rule, passed four acts of great importance, but without doubt no measure was ever of greater importance and of more far-reaching effect than that of 1882, regulating quarantine charges at the mouth of the Mississippi River. In fact, the results obtained in 1880, 1881, 1882 and 1883 should be regarded not only an important step forward for Louisiana but the results obtained in the field of public hygiene make these years the mark stones for the greatest progress in the medical history of the United States. Before 1880, physicians spent a great deal of time discussing the question as to whether yellow fever was imported or indigenous and, as is usually the case when doctors disagree, the public takes up the discussion and forms its own opinions. "Shot gun" quarantines were the popular pastimes during epidemics. The hostilities of influential citizens to quarantine regulations naturally had destroyed the confidence of citizens of the adjoining states.

In 1880, Governor Louis Wietz appointed Dr. Joseph Jones, Professor of Chemistry at Tulane Medical College and a former Confederate surgeon. President of the Louisiana State Board of Health. His great executive ability soon brought order out of chaos. He maintained that quarantine rested within the police powers of each state.

**Louisiana Supreme Court Decides Quarantine Is the Legitimate Exercise of the Police Powers of Individual States. Decision Upheld by U. S. Supreme Court, 1886**

In a case against Morgan's Louisiana and Texas Railroad and Steamship Company, the Louisiana Supreme Court upheld the contention of the State Board of Health in a decision in which the court said, "the establishment and enforcement of quarantine by individual states is not a regulation of commerce in violation of the Federal constitution, but is the legitimate exercise of the police powers by individual states, which are inalienable." This decision was sustained by the Supreme Court of the United States, January 1, 1886. Thus it happened that a firm basis for dealing with imported diseases, state quarantine and mode for action with neighboring states was established and Louisiana was placed, as well as other sea-board states, in a position to effectually protect itself as well as the rest of the country in times of epidemics.

**Radical Rule**

In order to appreciate conditions at this time, it is necessary to relate the results of Radical Rule in Louisiana.

*Louisiana Insane Condition, 1876.*—Probably the best example of the chaotic conditions prevailing is the memorial presented to the General Assembly in 1876, in regard to the Louisiana Insane Asylum in 1874 to 1875. There is no mistake that can be made as to the dishonesty and brutality practiced and the awful condition in which the pitiable, innocent victims were left. (Report of W. B. Londen, President of the Board of Administrators.)

**Progress of Medical Education**

The advantages offered in the way of abundance of clinical material, study of diseases of tropical and subtropical regions and fevers of warm climates, and an abundance of surgical cases, drew from earliest times medical students from many southern and western states of the great Mississippi Valley. This was a distinct advantage to the state in obtaining information also from outsiders. For example, Dr. T. S. Dabney, when a second-year medical student at Tulane, introduced the use of tincture of Cross-Root used by the Indians near Brookhaven, Mississippi, 1878.

In regard to the above-mentioned facts, the act of the legislature of 1886, which restricted applicants for positions of internes in the Charity Hospital to residents of the State of Louisiana, became inoperative July 1, 1888, which was a decided advantage to all concerned. In 1901, Tulane Medical College along with other first-class medical schools adopted the Carnegie unit system for students. After the close of the World War, Tulane University along with other leading universities began its preparation for a more systematic study of chemistry and for placing chemistry in its proper relation to medicine. In 1923, Tulane built its science building. The first and second floors of this building are devoted

almost exclusively to physiological chemistry. The cost of the building complete was $185,000 and the equipment cost approximately $35,000.

**Status of the Doctor Before the Civil War**

Owing to the fact that southern men had the time and money for study before the Civil War, the south was supplied with well-trained physicians—according to the teachings of their day. The medical students even at Bellevue were largely southern men. They needed a knowledge of medicine to take care of their slaves. However, at the breaking out of the Civil War, the Confederate Surgeon General published a manual on army surgery, as most of the men were general practitioners and the work on plantations involved very little major surgery.

**Druggist Sometimes Aids Doctor's Work**

The line of demarkation between the physician and druggist was not closely adhered to in those times. Very few druggists had anything but practical experience. The druggist was called upon to do minor surgery, blood-letting and cupping and could draw a tooth. Sometimes he would go out and make a case. His chief qualification was knowing what constituted a dose of medicine and the proper medicines to be given in different diseases. Nowadays, he is better qualified for analysis than for practical work. It is probable that the English were the most scientifically educated in pharmacy at this period.

The southern physician, who generally had means, usually possessed a fine medical library; therefore, we can surmise the tardiness in establishing a State Medical Library. Many did post-graduate work in Europe, especially in Paris. It was Dr. Joseph Jones, at the ninth annual meeting of the State Medical Society in Alexandria, Louisiana, April, 1887, who offered the resolution which led to the establishment of our State Medical Library.

**The School System**

We are gradually wiping out our 21.9 percent illiteracy as the state progresses and New Orleans becomes more than the "second port of the United States." The reason for its past existence is evident first from Spanish and French colonization; second, slavery; third, one of the great gateways of entrance for farm-labor emigrants. In reality, the immigrant who could read his own language could not be properly called illiterate, as he added his knowledge of Europe to that of the native. As the ignorant negro of slavery days was given the right to vote in national elections, it certainly was a wise step of Louisiana leaders not to give him this power in Louisiana; otherwise anarchy would have continued as in Reconstruction Days. It is a few of these old timers that give us a large part of our 21.9 percent of illiteracy. There are about equal numbers of negroes and whites attending the public schools today. The "drafty shack" along some bayou for a school building is purely a fiction if applied to present-day conditions. In what is known as the "Cajan" districts, referred to by Longfellow in his "Evangeline," Lafourche Parish, numerous fine brick schools line the banks of Bayou LaFourche with staffs of excellent normal-school graduates. The Anglo-Saxon and Latin races have learned a great deal from each other.

**Louisiana Pioneer Physicians**

Louisiana physicians can proudly boast of the first physician to advance the mosquito-theory of disease production. Dr. J. Nott, 1848, Professor in Tulane Medical College, invented the first inhaler for lung medication, and a specific for the bite of venemous serpents was offered by Dr. G. H. Tichenor, Senior. The first classification of mosquitoes in this section was made in 1899, by Dr. H. A. Veazie with the assistance of Dr. L. O Howard of the Bureau of Entomology (U. S.). The first and best culicide for epidemics was offered by J. C. Mims. The first successful cultivation of malarial parasite is due to Dr. C. C. Bass in association with Dr. F. M. Johns. The first specific for yellow fever, commercial hyposulphite of soda, which rendered this dreadful malady a very simple ailment, was originated by Dr. Geo. H. Tichenor, Jr.

Louisiana physicians have distinguished themselves on many lines of human endeavor, as soldiers, geologists, social workers, etc. With the assistance of Dr. Cowan, my father organized the medical officers of the Army and Navy of the Confederate States Association for the purpose of compiling Confederate medical and surgical records and was on the first committee on credentials.

The first contribution to the systematic geology of the State of Louisiana is recorded in Article XII in the transactions of the American Philosophical Society, Vol. 4 New Series, 1832, p. 397, *et. seq.*, entitled "Notice of Fossil Bones found in the Tertiary Formation of the State of Louisiana, by Richard Harlan, M. D.," read October 19, 1832. The article describes some large fossil bones found on the Ouachita River at a distance of about fifty miles by land and one hundred and ten by water from the town of Monroe.

Dr. Daniel Drake, in a volume entitled, "A Systematic Treatise, Historical, Etiological, and Practical, on the Principal Diseases of the Interior Valley of North America, as they appear in the Caucasian, African, Indian and Esquimaux varieties of its population," Cincinnati, 1850, also succeeded in weaving in many facts and statements of interest in regard to the geology of the state. On page 161, he states that the geological formation about Fort Jessup is Tertiary and advanced the gas theory for the formation of mud lumps (p. 91). Dr. Otto Lerch, under direction of Louisiana Experiment Station, spent from March 1 to May 18, 1892, studying the geology of northern Louisiana and, according to Wm. C. Stubbs, Ph.D. (Preliminary Report of the Geology in Louisiana), gave the first satisfactory published proof of the age of the large majority of the nearby fossiliferous beds of northwest Louisiana and gives a good description of the old works, including a figure showing his idea of the strategraphy of the region.

### Work of Recent Health Officers

The work of recent health officers have been along the lines of educating the public in health matters. To Dr. Oscar Dowling, present President of the Louisiana State Board of Health, is due the credit of reaching the rural population by means of the health car and to Dr. John Callan that of introducing (December 11, 1922) the first public health nurse for New Orleans.

When one reads medical literature, it is hoped that it will not be forgotten that the following are a few of our illustrious physicians: Riddell, botanist of note. Carpenter, botanist of note. Bass, grew malaria organism. Souchon, Edmond, anatomists, created Tulane's Museum of Anatomy, standardized the solution for preserving specimens in anatomy. Warren Stone, Richardson, Logan, Miles, Matas, surgeons of more than local repute. James Jones, Frank Hawthorne, S. M. Bemiss, masters of theory and practice of medicine. Nott, first announced the mosquito theory of yellow fever (1848) Duval, Couret, Gurd and Harris experimental work in leprosy and pellagra. Isadore Dyer responsible for legislation which created the Louisiana Leper Home. Deans of Tulane Medical College, 1835, Thomas Hunt; 1836, C. A. Luzenberg; 1837, E. H. Barton; 1840, I. H. Harrison; 1841-43, James Jones; 1843-45, I. H. Harrison; 1845, A. A. Canas; 1846, W. A. Carpenter; 1847-49, A. J. Wedderburn; 1849, James Jones; 1850-53, G. A. Nott; 1853-62, Thomas Hunt; 1865-85, T. J. Richardson; 1885-08, S. E. Chaille; 1908, Isadore Dyer; 1923, Chas. Cassedy Bass, Edmond Souchon, founder Southern Surgical and Gynecological Association. Ernest Sidney Lewis, founder of International Obstetrical and Gynecological Association. F. M. Johns with Bass was successful in cultivation of malarial parasite. Jacob Warren Newman, founder Lying-in Dispensary for the Poor. Oscar Dowling, while President of Louisiana State Board of Health, instituted conferences in New Orleans of National, State and Parish health officers to discuss medical questions in regard to public health.

It is with regret that space does not permit me to continue the honor role. This is why we are proud of

### Old Louisiana

There's a spot in this old country
  Endeared unto my heart,
At the very mention of its name
  I feel my pulse then start.
There seems to look from memory's frame
  From off time's hallowed wall,
The picture which I love so well—
  The one that meaneth all.

The gnarled oaks bend their branches down
  With moss draped here and there,
The birds upon their leafy boughs
  Send up their daily prayer.
The babbling brooks go rippling by,
  With echoes soft and sweet,
While in the thickets here and there
  The timid rabbits creep.

And the woods, I can't describe them,
  Though I see them now today,
And artists have but tried in vain
  Their beauty to portray.
Guyarré but partly told,
  Yet in most pleasing manner—
The beauties of my loved old state—
  My dear Louisiana.

Bienville, could you but return
  To look upon our soil,
And see the Mississippi,
  Around our old state coiled.
You'd deem your efforts not in vain
  But something wondrous kind,
You'd done for this old Southern State
  That bears you yet in mind.

And Audubon, the birds on high
  Make music soft and sweet,
They ever seem throughout the day
  Your name to fondly speak.
Then show me picture half so fair,
  Nor yet of pleasing manner—
There is not one to take her place,
  My loved Louisiana.

Mrs. G. H. Tichenor, Jr

# Bronchial Asthma

By MILTON COHEN, M. D., Cleveland, Ohio
Director of the Asthma Clinic, Mount Sinai Hospital, Cleveland, Ohio.

## Asthma a Protein Sensitization

IN the distant past, when illness was regarded as the result of the invasion of the body by evil spirits, a particularly malicious one must have been responsible for bronchial asthma. I know of no disease condition which causes more acute or nerve-racking symptoms than this one, bringing with it, as it does, a respiratory difficulty that is to the patient seemingly incompatible with the maintenance of life.

It is not surprising, therefore, that studious physicians from ancient times to the present day have searched diligently and painstakingly for its cause; attempting to apply each added bit of knowledge in its proper place; hoping that each new bit would be the key to the puzzle.

Space does not permit the review of all of the theories as to the etiology of bronchial asthma; suffice it to say that their number is legion and that no single one explains more than a few of the facts when it is subjected to critical analysis.

Most of our present-day theories have one point in common. They all recognize in the asthmatic patient a fundamental disturbance, an abnormal or pathological state which is recognized by many and various terms, among them being toxic state, sensitized state, anaphylactic state, allergic state. As this state is the basis of any rational discussion of this subject, let us examine the evidence for its existence and the experimental evidence upon which our knowledge is based.

While working on the standardization of diphtheric antitoxin, Theobold Smith found that, when guinea pigs had received a dose of antitoxin, and, after a period of two to three weeks, were given a second dose, serious symptoms and even death followed despite the fact that the second dose of antitoxin was too small to kill control pigs. Otto, Richet, Rosenau and Anderson made further studies of this phenomenon to which Richet gave the name *Anaphylaxis*, meaning, "without protection", the opposite of *Prophylaxis;* he established the fact that animals could be made sensitive to any protein substance.

When guinea pigs are given the second, or shocking, dose of a material to which they have been sensitized, a remarkable series of symptoms speedily develops. These symptoms are essentially respiratory in character. The animal so injected will, within a minute, vigorously rub its nose, sneeze spasmodically, and then begin to breathe rapidly. The breathing becomes more and more labored; the mucous membranes become cyanotic; urine and feces are passed involuntarily; tonic and clonic convulsions ensue. The respiration ceases, is resumed, becomes weaker and weaker and finally stops. The anatomic picture is that of extreme overdistention of the lungs caused by spasmodic constriction of the muscles of the bronchioles.

In bronchial asthma, the chief symptom consists in an expiratory dyspnea, during which there is marked bronchiolar spasm with acute overdistention of the lungs, and it was because of the similarity of this condition to anaphylaxis in the guinea pig that Meltzer, in 1910, suggested that asthma was related to anaphylaxis.

Critical examination of this conception, however, showed a number of differences, some of them fundamental in nature, between these two conditions, and the term *Allergy* was coined to apply to this condition of human sensitiveness to foreign protein. This condition does not depend on a sensitizing dose of protein but is inherited, and patients may have symptoms of allergic phenomena the first time they come in contact with a definite protein substance.

## Desensitization

In seeking to protect animals against the illness or death following the second dose of protein, Besredka studied the effect of many substances, in inhibiting this phenomenon. Briefly, he found that all lipoidal substances and substances having an affinity for lipoids, such as ether, chloroform, alcohol, ethyl chloride and chloral hydrate, were particularly efficacious, as was also the intravenous injection of sodium bicarbonate. These observations were overshadowed, however, by the accidental discovery of the fact that a dose of the substance to which the animal is sensitized, if small enough to cause only slight symptoms, will give protection against several lethal doses of the same material. In this way, the conception of desensitization was born.

Before this method could be applied in the treatment of asthmatics, it became necessary to determine whether asthmatics could be demonstrated to be sensitive to any definite materials and whether attacks could be produced at will with these materials. In 1873, Blackly demonstrated that hayfever and its accompanying asthma were caused by the inhalation of pollens by individuals who were sensitive and that those pollens, when rubbed into the skin, would produce an urticarial wheal in sensitive individuals. This method of skin testing has been elaborated by many workers, and individuals have been shown to be sensitive to many substances divided into the following large groups for purposes of convenience:

1. Pollens
2. Foods
3. Animal emanations
4. Bacteria
5. Other air-borne substances, such as dusts, sachets, etc.

Before an individual can have symptoms, however, he must have this fundamental disturbance known as the allergic state.

Treatment, therefore, resolves itself into two problems:

1. Relieve the allergic state.
2. Keep the patient away from things to which he is sensitive.

### Haseltine's Work

In the past two or three years, a somewhat different aspect of this entire problem has been presented by Dr. Burton Haseltine, who regards the allergic state as a toxic condition due to infection. The asthmatic attack represents a bronchiolar spasm induced through a reflex arc, by way of the fifth nerve, through the nucleus ambiguus and the dorsal nucleus of the ascending vagus root. The sensory end-organ for this reflex arc is the ethmoid area of the nose.

He regards the asthmatic patient as a highly toxic patient with a delicate state of balance between elimination and excretion, which balance can be disturbed by a variety of causes and an asthmatic attack can thus be induced.

According to Haseltine, treatment depends on complete detoxication of the patient, using all of the eliminative organs, and the removal of all foci of infection wherever found. The rhinologist's part in this treatment is extremely important, as much depends on relieving abnormalities in the nose and more particularly in the ethmoid area. A not inconsiderable part of the success claimed by him is due to his painstaking individualization to meet the problems presented by his patient, and to the use of the Dowling method of nasal tamponage which seems to be particularly efficacious in combatting infections in the submucous tissues.

Comparatively recently, Novak and Hollender reported their observations on the calcium content of the blood in various allergic states and in the use of calcium salts combined with thyroid extract or ultraviolet light in raising the blood-calcium content. Their work needs the confirmation of other careful workers and a much more extended clinical trial before final judgment can be passed on it.

Both, this method and that of Haseltine, approach the relief of the patient through the cure of the allergic state, as does the method of desensitization mentioned earlier in this paper. When one does not succeed in thus relieving the allergic state, one must apply treatment under group 2 which attempts to create a special artificial environment in which the patient can live in comfort.

### Coming Down to Cases

Now, what are we as doctors to do when a patient with asthma applies to us for treatment? We begin as with any patient by taking a careful history, asking especially about family history concerning any allergic phenomena, such as hayfever, asthma, eczema, angioneurotic edema. It is important, also, to determine the age at which attacks began, the season at which they occur, if any, and the longest interval of freedom between attacks.

The physical examination also is done just as for any other condition. The functional capacity of the heart and kidneys must be ascertained, as many socalled asthmatics referred to us have dyspnea due to heart, lung or kidney disease and are not true bronchial asthmatics. Careful search for foci of infection must be instituted.

Having determined all of these factors, we next proceed to laboratory examinations. Those which are performed routinely are: (1) Blood chemistry, including non-protein nitrogen, urea nitrogen, creatinine nitrogen, uric acid nitrogen, glucose, calcium and phosphates; (2) Uranalysis; (3) Complete blood ccunt; (4) Sensitization tests; (5) Sputum examinations; (6) X-ray studies of head, teeth, chest and gastrointestinal tract as indicated by individual cases.

When the results of all these examinations are at hand, therapy is planned for the patient. This therapy is not routinized, but is applied to meet the individual requirements presented

by the patient. It includes removal of foci of infection, stimulation of normal physiological excretory mechanisms, specific immunization, and the administration of pharmacological preparations as indicated.

Therefore, as you can see, the asthmatic patient is a sick individual, needing not some one specialist's particular method but the skilled use of all the methods of medical science combined with good clinical judgment.

When the patient is fortunate enough to receive this type of care and is faithful in carrying out his part of the treatments, very excellent results can be and are being obtained.

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# The Value of Bacterins in Practice*

By EDWARD CALVIN LAVERTY, Louisville, Kentucky

THAT bacterins (killed germs in salt solution) are of value as therapeutic and prophylactic agents, there is now no question. To be sure they do not in every instance of infection stay the disease and cure the sufferer. Such an ideal agent does not exist and no thoughtful physician would expect as much. Those who question the value of bacterins have had no extensive clinical experience with them, have not efficiently used them, or have not used them at all. It is interesting to note that those who questioned their value on theoretical grounds are fading out in the face of large clinical experience. Notably those who dogmatically stated that if there was any therapeutic value in bacterins they must be autogenic preparations in order to have the specific antigens.

The therapeutic results with stock bacterins and nonspecific proteins have now been so extensively proved and for such a long period that these contenders must cease to contend. It is true that some times the autogenic bacterins must be used, especially if well selected stock bacterins seem to fail.

The fundamental principle of bacterin therapy is stimulation of the natural immunizing forces of the body to produce antibodies in the healthy tissues, away from the site of infection, for the purpose of getting rid of the offending invaders (germs) and neutralizing their toxins. That this does occur has been proven by Sir Almroth E. Wright and others in extensive research work, and by the clinical results obtained by many thousands of physicians throughout the world.

In 1918 few physicians were using mixed bacterial vaccines in pneumonia. Many good men were strongly antagonistic to their use in this highly fatal disease solely on theoretical grounds. Today, mixed formulas of pneumococcus, streptococcus, micrococcus, catarrhalis, Friedlander bacillus, and similar organisms are not only extensively used in the treatment of pneumonia but are fast approaching the standing of diphtheria antitoxin in what has been a highly fatal disease.

The failure to get successful results from the use of bacterins in the treatment of infectious processes, where they would be indicated, is due to a number of factors, some of them known, some probably not known at this time. We must remember that in dealing with immunizing forces there are complex phases that interfere with favorable results in some individuals, yet the proportion of good results unquestionably justifies their use in all conditions due to germ invasion and activity.

That the use of bacterins is a harmless procedure is now apparently beyond question, for their use during the past fifteen or more years and their extensive use in the past five years, have brought out no statistics to the contrary.

Bacterial vaccines must not be confused with serums or toxin filtrates that have been brought out from time to time, and occasionally cause an anaphylaxis. Anaphylaxis, however, is due to an idiosyncrasy of the patient to the serum or toxin filtrate. I have never seen or heard of an anaphylaxis following the use of bacterins. Occasionally a severe reaction will occur, but today many users of bacterins consider a good reaction essential to the best results, notably in treating gonorrhea. Stimulation of the natural fighting forces in the human economy against bacterial invasion and destruction is essential.

In the light of the knowledge we now have on the subject, procedure toward activating the immunizing forces is as sensible as activating other functions and organs of the body. The time is near when failure to do this will be looked upon as an inexcusable neglect which will place the guilty physician in a position for severe criticism. The time for saying, "Let your patients alone, they will get well if you give Nature a chance by letting her alone,"

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*Reprinted from *Medical Journal and Record*, July 16, 1924.

is over. The physician is consulted by the patient with the expectation, and justly so, that the man learned in anatomy, physics, physiology, pathology, bacteriology, therapeutics, etc., can aid Nature in overcoming the condition which the physician is asked to treat.

The physician's moral duty is to do his best and in order to do so he must keep abreast of the times and study carefully and intelligently those agencies that are brought forth from time to time that will improve his technic and obtain better results. It has been said, and no doubt it is a fact, that seventy-five percent of our patients would recover without the services of a physician. If this is true, our real problem is with the remaining twenty-five percent. Let us then strive to improve materially or relieve the sufferings, and reduce the mortality of this twenty-five percent. This is the real test of a physician's ability.

I do not believe that my contention will be denied that the majority of our real problems in medicine are due to infections. Then, the subjects of bacteriology and immunology stand out as foremost factors in our work and should receive the most earnest consideration and study on the part of the practitioner and surgeon.

The best technic in surgery counts for naught if the patient dies, so the real test of a surgeon's good work is, not so much good surgery, but satisfactory recoveries. Might it not be possible that the practice of preoperative and postoperative immunization against the well known pathogenic organisms in surgery would reduce materially the socalled complications, that frequently either kill the patients or leave them invalids to be held up as warnings against surgery?

Several months ago my wife had appendicitis. Immediately upon the manifestion of symptoms of the disease, I gave her one-half cubic centimeter of a stock bacterin. Eight hours later, just before going to the hospital, she received a full Cc. of the same bacterin. This procedure was simply to aid Nature's fighting forces to care for the postoperative conditions. On incision the surgeon found adhesions and a bad streptococcus infection (no pus) of the appendix. It was removed and the incision closed. The condition warranted the grave attitude of the surgeon at the conclusion of the operation. To the surgeon's surprise the patient's recovery was ideal; she left the hospital in twelve days. She probably would have recovered without the use of the bacterins, but unquestionably they did no harm. The unusually good results following a careful surgical operation in this case justify the belief that the bacterins rendered valuable service.

A few weeks later a friend, with a much less serious infection, underwent a similar operation by a first class surgeon. After seven weeks of severe suffering from postoperative infection her condition was still serious. No bacterins were used in this case.

The circumstances and results in these two cases give food for serious thought.

### The Comparatively New Nonspecific Protein

The use of a comparatively new antigen, sterilized milk, usually mentioned as milk or lactic antigen, is filtering into our armamentarium of immunizing agents very rapidly. Much has been accomplished in Europe and in this country with this new stimulant to the immunizing forces, and it behooves every physician and surgeon to give it careful consideration and extensive use with critical observation to obtain its true value in medicine. It is, of course, a nonspecific protein stimulant to antibody production.

The possibility of nonspecific protein therapy was long ago recognized and established by Sir A. E. Wright and other authorities in the field of immunology. The extent of its value, however, must be proved by extensive clinical evidence. In preparing this milk antigen great care must be used in the selection of the milk which must be free from pathogenic organisms, especially tubercle bacillus. Even milk from certified dairies must be carefully sterilized. It is best prepared in laboratories equipped for the purpose.

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# Sciatica and Its Relation to Spinal-Cord Disease

By BENJAMIN FINESILVER, M. D., New York

RECENTLY, investigators have concluded, that an idiopathic sciatica is not a distinct clinical entity but only a manifestation of a coexisting condition. Accepting this as a fact, this painful affection is then merely a symptom, the result of some definite underlying factor producing it. It is obligatory, therefore, when attempting to arrive at a just conclusion, to use every available diagnostic method, so that the true etiology may be determined. As such, it is the purpose of this paper to show that sciatica, in its earliest phases, may be a precursor of some form of spinal-cord disease. To attain this end, a careful and detailed anamnesis is most essential. The physical examination must be complete, with especial emphasis upon the neurologic findings, supported by repeated and adequate laboratory and Roentgen-ray investigations.

Ordinarily, we have an organic sciatica, or sciatic neuritis, and a simple sciatica, sciatic neuralgia. The former is frequently due to endogenous causes, such as toxins arising from some focal infections, (either teeth, intestines, gall-bladder, prostate, etc), or due to exogenous toxins, as alcohol, lead, etc., causing at times a neuralgia or, in the severer forms, a neuritis.

### Pathology

Cases of lead poisoning, producing sciatic neuritis, show definite pathologic changes microscopically. The medullary sheath in parts becomes narrower, cloudy and granular, while the axis-cylinder remains intact. The outer sheath and nuclei present little alteration. The pathologic changes at times are more considerable, and often simulate Wallerian degeneration. The myelin sheath may undergo segmentation, the axis cylinder may break up, and the nuclei and protoplasm of the sheath increase. In the spinal cord, however, cases presenting signs of a very marked and advanced neuritis may show very little change. Other investigators (Vulpian, Monakow) have reported cases where examination of the cord revealed definite changes in the form of atrophy or pigmentation of the ganglion cells of the anterior cornua, slight in some and considerable in others. Thus, an organic sciatica, with pathologic changes involving the sciatic nerve, may be a sciatic neuritis or an affection of the neurons whose fibers take part in the formation of the sciatic nerve, a neuronitis, or a combination of the two morbid conditions above described.

### Diagnosis

In these painful affections of the sciatic nerve, spontaneous pain can often be elicited by causing pressure along certain special points of tenderness, namely: over the sciatic notch, the mid-popliteal space, the gluteal crease, opposite the head of the fibula and over the course of the anterior tibial nerve. Producing tension and stretching of the nerve will give rise to intense pain and is also of diagnostic importance. The latter is induced in various ways. After placing the patient in the horizontal position, the leg is extended at the knee and the foot is slowly raised. When the foot has been separated from the horizontal rest, but only a distance of from 40 to 50 centimeters, a sudden and severe pain on the posterior aspects of the thigh is produced. However, as soon as the knee is bent and the tension on the sciatic nerve is released, the pain is gone and the patient is relieved. This is known as Lasèque's sciatic phenomenon. If the patient is told to stand with his hands on his hips and then is asked to flex the trunk laterally, first to the right and then to the left side, without bending the lower limbs, a limitation of lateral flexion will be observed, as a rule, on the side of the pain, more rarely on the opposite side. Or, if the patient be placed flat on his back, and the affected limb placed in maximum extension, and if the foot is then suddenly flexed, thus producing an elongation of the sciatic nerve, especially the posterior tibial, an immediate pain "defense" movement occurs in genuine cases, which is shown by flexion of the leg upon the thigh and the thigh upon the pelvis, so as to relax the elongated nerve.

Rogers claims that the pain elicited by hyperextension tests in sciatica is not due to the stretching of the nerve, but to the pull on ligaments of the sacroiliac joint. He attempts to prove this by placing the patient in the prone position and hyperextending the thigh. This also elicits pain similar to that of increased tension on the sciatic nerve, although the pull is on the sacroiliac ligaments in the opposite direction and in a position in which the nerve cannot be pulled upon. Whether this is so or not is not the object of this discussion, but it suggests that sacroiliac pain is often associated with sciatic pain, the latter

with affections of the sacroiliac joint and the former frequently with affections of the sciatic nerve. In affections of the sacroiliac joint, in nearly all cases, pressure over the joint causes acute pain over the course of the sciatic nerve, while the pain directly over the joint is of greater intensity than along the painful spots over the sciatic-nerve distribution. In addition, there is almost always an existing positive fabere sign or Patrick's test, (i. e., flexion, abduction, external rotation and extension of the thigh elicit sharp pain in the sacroiliac joint, if that be involved). In sciatic neuritis, the patient obtains some relief from pain by assuming the semiprone position, with hip and knee flexed, so that all strain and tension is relieved from the sciatic nerve. Should the trouble be within the sacroiliac joint itself, relief would not be so prompt. In this instance, a diagnostic and therapeutic aid would be, the fixation and immobilization of the joint. If the joint were involved, relief would now occur.

Sciatic-nerve involvement may give rise to sensory disturbances, with degenerative atrophy of the musculature and diminution of the Achilles jerk. The Achilles tendon on the affected side is more relaxed than on the sound side, and the gluteal fold is lower, showing definitely more flaccidity than on the sound side. However, this should arouse suspicion of a more serious affection, as such signs are frequently indicative of intrapelvic or intraspinal disturbances, producing compression of the nerve or of the nerve roots. A rectal or vaginal examination is obligatory and may reveal a retrouterine hematocele, a fibroid tumor of the uterus, chronic constipation with fecal impaction in the rectum, tumors of the sacrum; in the male, carcinoma of the prostate with metastases—all tending to cause compression of the nerve within the pelvis. Tuberculous osteitis, tuberculosis of the vertebræ, and tumors of the cord are factors at higher levels producing sciatic symptoms. Such constitutional conditions as gout, tuberculosis, lues, malaria, typhoid, influenza and gonnorrhea may give rise to the same.

Should intrapelvic pressure be the source of the subjective pain, the tender spots along the course of the nerve would not readily be elicited by manual palpation. Should there be no tenderness along the sciatic-nerve trunk, and if rectal, vaginal and x-ray examinations reveal no intrapelvic masses and no pathology in the sacroiliac joint, then our attention must be immediately drawn to the spinal cord or vertebral column. The more common pathological cord conditions giving rise to sciatic pain are, tumors of the dura, tumors of the cord, pachymeningitis, meningomyelitis, multiple sclerosis, spondylitis with subsequent pachymeningitis and myelitis. Very often the shooting and lightning pains occurring in the incipient stage of tabes will be mistaken for sciatica. However, such ocular signs as Argyll-Robertson pupils, or a slight ptosis of the lid, or a slight ocular palsy, or even a beginning optic atrophy or slight sensory disturbances (tingling of the hands and feet, perhaps some areas of hyper- and hypesthesia, allocheiria or retardation of sense of pain), with or without bladder disturbances, easily reveal the nature of the malady. The loss of deep tendon reflexes plus the pupillary changes should fix the diagnosis in our minds. As cooperative aids, the four-phase reactions (blood- and spinal-fluid Wassermann, cytological examination and colloidal-gold curve) with physical findings, leave no further doubt as to the diagnosis.

### When the Cord Is Involved

Sciatic symtoms occurring as a result of cord pathology are more usually bilateral than in pure nerve involvement alone. In sciatic neuritis, there is an increasing sensitiveness of the musculature to pressure, while such sensitiveness is absent in pathology of the cord giving rise to sciatic symptoms. In the latter, there will at some time occur vesical and rectal disturbances: at first, difficulty in starting the stream with a sensation of not having emptied the bladder, soon to be followed by symptoms of urgency. Sneezing and coughing may produce very acute pains in tumors of the cord, especially over the areas of the affected roots. This pain is due to the effect of the sudden increase in the intradural pressure on the diseased and irritable nerve fibers (*Signe de l'éternuement*).

The appearance of increased reflexes in a patient presenting features that simulate a sciatic neuritis should immediately arouse suspicion of spinal-cord involvement. If the former be the case, the reflexes elicited are usually diminished or not obtained. This state of affairs is entirely out of proportion to the amount of the sensory disturbances found. If the affection is within or about the spinal cord, an early and important symptom is that of radicular pain. This pain is due to irritation of the dorsal roots and, owing to this increased irritability, an ordinary stimulus giving rise to a normal response would produce an exaggerated one in this instance. In the early stages, the skin over the area of spinal

involvement is hyperesthetic. As the disease progresses, this hyperesthesia gradually diminishes owing to slow degeneration and destruction of the sensory-root fibers. Later, the area which was formerly hyperesthetic gradually becomes hypesthetic. Along with this, the patient complains of increasing weakness of the extremities, associated with hypertonia.

The spinal fluid is of aid when the growth has given rise to some degree of pressure. Under such circumstances, one gets an increase in the amount of albumin, accompanied by an increase in the number of lymphocytes (2-12 per cmm.). Should there occur a tumor of the meninges, the spinal fluid is accompanied by an abundant cellular reaction, the cellular substance consisting chiefly of neoplastic cells. If the compression of the cord is marked, the albuminocytologic dissociation is almost constantly present and may be accompanied by xanthochromia. Often, if symptoms present are due to cord neoplasm and, if a sensory level could not be determined, spinal puncture may aid in eliciting this level sought.

### Lumbar Puncture

In 1914, Raimiste reported four cases, in which patients presented themselves with pain in the posterior aspect of the thigh, some tenderness on pressure over the sciatic nerve, and even with Lasèque's and other concurrent signs sufficient to render a diagnosis of sciatic neuritis, but with hyperreflexia and only slight sensory disturbances. He made lumbar punctures in these individuals and found the spinal fluid to be under increased pressure, with positive Nonne-Apelt (globulin) reaction. These patients were all cured by repeated lumbar puncture, the final diagnosis being that of a meningomyelitis with referred symptoms of sciatic neuritis. In these cases, not only did lumbar puncture play the role of diagnostic aid, but also that of a definite therapeutic agent.

Tinel and Gastinel have also shown, that a meningitis of the lower cord may cause symptoms suggestive of sciatic neuritis. They reported an interesting case of a young male adult, 28 years of age, who had had a tuberculous pulmonary infection for about six years. The patient later died as a result of this. Thirteen months previously, he had complained of severe pain in the left thigh, with symptoms and signs pointing to a sciatic neuritis. His pain was severe, and he was confined to bed for two months. Autopsy revealed an acute tuberculous meningitis superimposed upon an old one. In the lumbar region of the spine, was found old cicatricial tissue in the first and second nerve roots. The latter findings apparently explain the cause of the painful attacks referred to the sciatic nerve distribution.

### Case Histories

Briefly, the following two cases are those of spinal-cord tumor whose early manifestations presented themselves in a form suggesting sciatic neuritis:

Case 1.—A. M., female, 20 years of age, typist, single, native whose family history was negative, and whose past history was negative except for salpingo-oophorectomy for twisted ovarian cyst, and for appendectomy. Her chief complaint was, pain in the left thigh and leg and lumbar region, associated with some difficulty in walking. Eight months previously, she had complained of a knife-like pain in the thigh and leg which had to be controlled with morphine. Some time later, she experienced a similar pain in the opposite limb. The condition was diagnosed as that of sciatica and patient was treated accordingly. Up to the time of admission, there was a gradual weakness of the extremities with some difficulty in walking.

*Physical Examination.*—The positive findings were: Some weakness of the hamstrings on the right. The knee and ankle jerks were bilaterally increased. Occasionally, fibrillary twitchings in quadriceps on left, with slight atrophy of left leg and thigh muscles. Right lower abdominal reflex not elicited, perhaps due to scar of previous operation. There was definite tenderness on percussion over the 8th and 9th dorsal vertebræ. There was a level of hyperalgesia corresponding to the 10th dorsal level on the right, with hypalgesia and hypesthesia over the 12th dorsal segment, and some perianal hypalgesia on the right. The condition was thought to be a tumor of the cord at about the 8th or 9th dorsal level, probably extradural. A laminectomy was performed over D10 to L2, and an extradural tumor was found attached to the dura posteriorly and laterally to about 2 cms. above the conus, the diagnosis of which was lymphangio-endothelioma.

Case 2.—H. S., male, 36, married, native, metal worker, whose family history was negative and whose past personal history was negative except for Neisserian infection at the age of 29. His chief complaint was pain in the thighs and legs radiating to the hips. The pain was more severe on the right side and was of a stabbing and lightning character. The condition was repeatedly diagnosed as sciatica, and the patent received three in-

jections into the sciatic nerve without relief. He soon complained of numbness in the soles of his feet, the right more so than that of the left. Later, his legs became weak, so that he experienced great difficulty in walking. A short time after, he complained of difficulty in starting the urinary stream, followed by frequency associated with increased constipation.

*Physical Examination.*—The positive findings are: The muscular power of the lower extremities are somewhat diminished, with a coexisting hypertonia and hyperreflexia. There is a bilateral ankle clonus and patella clonus present, and a bilateral Babinski present. There is a belt of hyperesthesia at the level of 7th to 9th dorsal segments, with spinal tenderness over the 10th dorsal vertebra. The lower abdominal reflexes are diminished, the left more so than the right. The cremasterics are absent. The spinal fluid shows a trace of globulin, otherwise is negative. The condition was thought to be an extramedullary tumor of the cord. Laminectomy performed and nonoperable tumor found, the biopsy report of which, was fibroendothelioma.

Meningovascular lues may give rise to symptoms simulating sciatica, as is briefly illustrated by the following case.

Case 3.—B. A., female, 24, single, dress operator, Russian. Family history and past personal history apparently negative. Her chief complaint was, pain in the thighs and legs. This began fifteen months prior to admission, with sharp, stabbing pains in the right thigh extending down the leg. This pain continued intermittently for about two months, after which she noticed gradual weakness and difficulty in walking. This was soon followed by vesical disturbance (retention), so that the patient had to be catheterized. The condition continued to progress, the right lower extremity growing spastic and apparently weaker.

*Physical Examination.*—The positive findings were: In walking, patient seemed to drag the right leg. Her eyes showed a bilateral ptosis and a bilateral nystagmus. The pupils were irregular, hippus present in both eyes. The upper extremities showed a bilateral weakness, with bilateral ataxia and loss of deep muscle sense. The deep tendon reflexes were hyperactive. Astereognosis of the left hand. The lower extremities showed impaired motor power, with atrophy of quadriceps on right. There was a bilateral adductor spasm. Right knee and ankle jerks not obtained. Ankle clonus on left. Blood- and spinal-fluid Wassermann, four plus; after intensive antiluetic treatment, they were both negative. The condition was diagnosed as a meningomyeloencephalitis of luetic origin, the symptoms complained of being due to the cord or meningeal involvement.

**Multiple Sclerosis**

In multiple sclerosis, the increased proliferation of the neuroglia and sclerotic patches may at first invade the spinal cord. Such cases have even been operated on for supposed spinal-cord tumor. In producing signs and symptoms of the latter, in its incipiency, the affection makes itself known in the form of a sciatic neuritis. Here the classical Charcot triad (nystagmus, intention tremor and scanning speech) is almost always absent and must not be depended upon in rendering a diagnosis of multiple sclerosis. In such difficult and borderline cases, one must remember that multiple sclerosis is characterized by multiplicity of lesions, by irregularity of involvement, by remissions and exacerbations, and by absence of one or all abdominal reflexes. In addition, there may be an early optic atrophy, with signs of pyramidal tract involvement (Babinski, ankle clonus, etc.) or nystagmus, intention tremor, etc. The following case will briefly attempt to illustrate a case of multiple sclerosis, whose initial symptoms, years before, suggested sciatic-nerve involvement.

Case 4.—M. R., female, 34, native, dressmaker, whose family and past personal histories were negative. Her chief complaint was pain in the thighs and legs with difficulty in walking. This pain began 10 years ago, in both legs and thighs, severe and stabbing in character, confined to the posterior aspects of the thighs, extending down the legs. This pain was exaggerated on standing and walking, relieved by relaxation and flexion at the thighs and knees. It occurred irregularly, at intervals of days and, at times, weeks. About two years later, she noticed an uncertainty of gait and would occasionally stagger. The pain and uncertainty of gait would often become worse and, after remaining in bed for a few days, the symptoms would entirely disappear, only to return again soon after. In November of 1922, there was a marked exacerbation of all these symptoms, and the patient was compelled to take to bed.

*Physical Examination.*—The positive findings were: Pupils were unequal, the right larger than the left. Nystagmus bilaterally present. Left supranuclear facial weakness was present. There was a definite intention tremor of the upper extremities, the right greater than the left. There was a bilateral

ataxia, the right greater than the left. The deep tendon reflexes were exaggerated. The lower extremities were markedly hypertonic, with marked adductor spasm in the thighs. The ankle- and knee-jerks were hyperactive, with bilateral ankle clonus and Babinski present. Definite loss of proprioceptive sense and vibratory sense up to the iliac crest. Colloidal-gold curve of spinal fluid was 445332200; otherwise was negative. The condition was thought to be one of multiple sclerosis giving rise to the symptoms complained of.

A traumatic or infectious spondylitis may cause an inflammatory communication from the vertebræ to the meninges. As a result of the former, a pachymeningitis may be induced, with subsequent production of pressure and even inflammation of the cord. Should this condition occur in the lumbar region, the resulting pathologic changes would produce referred pains to and along the distribution of the sciatic nerve, with symptoms simulating a sciatic neuritis.

Case 5.—A. R., female, 26, English, dress-finisher. Her family history was negative. Her past history was: operated upon for tuberculous osteitis of left femur, in 1907, 1908 and 1910, with subsequent shortening of the left lower extremity. Her chief complaint was pain in the right thigh and leg. The present illness began, following a fall from a street car. This started with sharp, knife-like pain in the right thigh and leg, which was almost constant. The pain was exaggerated when she was up and about, and somewhat relieved upon relaxation. This pain became so intense that she was compelled to take to bed for a period of ten weeks. At that time, the right extremity was very weak and, in walking, felt as if she were stepping on a carpet. This was soon followed by bladder and rectal disturbances (difficulty in starting, later frequency and urgency).

*Physical Examination.*—The positive findings were: The left lower extremity is 3 inches shorter than the right. The lateral margin of left thigh shows 3 parallel scars of previous operations. The tendon reflexes of the lower extremities were hyperactive, the right more so than the left. There was a bilateral Babinski, greater on the right than on the left. There was a level of hyperalgesia at the 12th dorsal segment, with diminution of touch, pain, thermal, muscle and vibratory sense up to that level. The diagnosis was that of a compression myelitis, due to extension of the bony disease of the vertebræ. An Albee operation was performed, six weeks after which all symptoms had disappeared.

These cases briefly tend to illustrate the manner in which spinal-cord affection, in its incipiency, may manifest itself in the form of a sciatic neuritis, and they will further tend to impress the importance of accuracy in determining the underlying factors producing the symptoms and signs.

### Conclusion

1.—The etiologic factors producing symptoms of sciatica are varied.

2.—The local symptoms are frequently referred from other areas.

3.—Careful anamnesis, thorough physical and laboratory aids should be employed in every case presenting sciatic symptoms.

4.—Symptoms of sciatic neuritis are often precursors of spinal-cord disease.

5.—Sciatica is truly a symptom, and not a distinct clinical entity.

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# The Use of Dyes in Medicine

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IODINE and picric acid are the two dyes with which the physician has been acquainted longest. At some time or other, they have been used by nearly every doctor. Although both have serious disadvantages, they have, nevertheless, performed valiant service to mankind. They not only accomplished the therapeutic results expected of them but also presented the patient with convincing evidence that something definite had been done for him. As a result, the household medicine-chest now generally contains tincture of iodine and, frequently, picric acid solution.

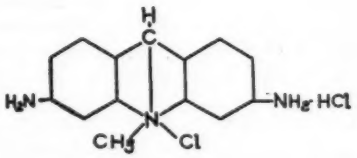
Dyes have found their greatest use in medicine as antiseptics and bactericides. For this purpose a dye has two distinct advantages over products that do not stain. It becomes fixed to the tissue and is, therefore, able to exert its antiseptic action for a period of several hours. Furthermore, it penetrates into the issue; and one can *see* that it does this. Although some of the colorless antiseptics may possibly stick just as tenaciously and penetrate just as deeply, the action cannot be followed by the eye. In the case of colored antiseptics that do not stain, one can see that the period of their action is usually very brief.

Work done in Ehrlich's laboratory, in an attempt to find dyes of use in diseases caused by protozoal parasites, has been the indirect stimulus for some of the developments in the field of antiseptic dyes. Under his direction, two dyes in the azo series, similar to congo red, were developed; trypan red, which attacks the trypanosome of the South American horse disease, "mal de caderas", and trypan blue, which is effective against the trypanosome of the cattle disease, "piroplasmosis".

The acridine series of dyes was then studied and, in 1912, a product was synthesized that promised to be effective in combating the trypanosome of African sleeping sickness. This dye Ehrlich called trypaflavin and it is still known by that name in Germany. In Canada, England, and the United States it is now called acriflavine.

Following the publication of the original paper, no more work with this product appeared until several years later when Browning, of Glasgow University, a former assistant of Ehrlich, became interested in antiseptic and bactericidal dyes. The relative effectiveness of a number of products (phenol, mercury bichloride, iodine, malachite green, brilliant green, crystal violet, ethyl violet, and various others) was studied and from his results, published in 1917, it was concluded that "of all the substances examined, the compound acriflavine stands out as possessing the highest sum of desirable properties for therapeutic purposes, that is, great antiseptic power along with relative nontoxicity toward phagocytosis and lack of irritating effect on the epithelium".

Acriflavine proved to be very effective clinically and was soon widely used by surgeons in the Allied Armies for treating wounds. Acriflavine was later found to be very effective in the treatment of gonorrhea and its use for this purpose was soon favored by many physicians.




ACRIFLAVINE
*3-6-Diamino-10-Methyl Acridinium Chloride Hydrochloride*

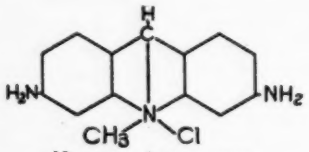
As the use of acriflavine increased, the desirability of a neutral product was realized. Neutral acriflavine, which is acriflavine from which the molecule of hydrochloric acid has been removed, was accordingly developed and thus the drug was presented in a still more desirable form.

New uses for neutral acriflavine have continued to appear. Its use in eye, nose and throat work and in certain skin diseases have been favorably reported. Davis has recommended it highly for oral use as a urinary antiseptic—it being the best of nearly 400 products which he tried for this purpose.

Neutral acriflavine has also been given intravenously with generally favorable results in a number of diseases such as puerperal sepsis, gonorrhea, septic abortion and lethargic encephalitis. Although the intravenous use of the product is not yet extensively practiced, there is every reason to expect that this method of administration will prove useful

in many cases.

Acriflavine and neutral acriflavine have found more extensive use in medicine than any other dye introduced in recent years and many articles have been published describing their use. They have become the standard of comparison for all new products of this sort.




NEUTRAL ACRIFLAVINE
*3-6-Diamino-10-Methyl Acridinium Chloride*

Research with dyes is continually in progress aiming to develop superior products. Articles are frequently published describing new compounds and new applications of old ones. Some look promising for a time and then fade from notice, while others, which seem to be of value, have not yet been given a sufficiently thorough trial. It is evident that the results of many workers are necessary before a new product becomes established to the point where it can be used with confidence. The introduction of new and superior remedies of any sort is truly a most necessary but at the same time a very painstaking and slow task.

About two years ago, German workers reported that another acridine dye, called rivanol, was remarkably effective against streptococcic infections—almost specific in its action. Authors of more recent articles, however, seem to be of the opinion that it is not as promising as was hoped and is inferior to acriflavine. Another German acridine dye, flavicid, was presented, *cum magna laude*, about three years ago, and now is almost forgotten.

Within the last six months, gentian violet and mercurochrome have been reported as useful in the treatment of septicemia and further work with these products is awaited with interest.

A more extensive use of dyes in medicine is almost certain to come. At the present time, their chief use is as antiseptics, a use for which their ability to stain admirably fits them. This same property makes them a fertile field in which to search for the remedies that will eventually be developed for such bacterial diseases as tuberculosis and pneumonia. To accomplish this, dyes must be found that will attach themselves to and kill these bacteria and at the same time be relatively harmless to human tissue—a difficult task, but surely not an impossible one.

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# Random Notes From the Record Book of a Country Doctor

**By E. S. GOODHUE, M. D., Roosevelt, Molokai**

**These Notes, Observations, Opinions, and Inferences, Are Based on Clinical Data and Experience**

WE sometimes find that the very thing we want information about, be it condition, anomaly, symptom, or treatment, is hardly touched upon in the textbooks or journals at our command; or, if referred to by them, it is in such an indefinite or unsatisfactory way that we are left in doubt and, in the country especially, thrown upon our own good sense, skill and experience, which may or may not be adequate.

There is a great deal said about the suppression of urine, its causes, symptoms and treatment; but, on reference to some seven or eight recent works on Practice, I find little about the obscurer causes of retention.

Kerley says that retention of urine may result from injury, vaginitis, gonorrheal sequelæ, phimosis or stone. For treatment, he suggests hot stupes over abdomen, sitz baths, the sound of running water, catheterization.

So far as I know, Fussell, in his last edition, on Practice, gives the most detailed information regarding the causes of mechanical retention, and its reflex relation to incontinence of urine, a much simpler and more common dysfunction.

We have all racked our brains and drug lists in an effort to stop bed-wetting, but, in my experience at least, aside from retention due to gonorrheal and prostatic lesions in men, I have not met with many complicated cases of retention.

In lesions of the spinal cord above the lumbar enlargement, when the action of the bladder depends on the reflex center of the lumbar cord, and voluntary-sphincter power is lost,

we have retention of urine as long as the sphincter action lasts. But, when the accumulated urine stimulates the *extrusor* by pressure, retention ceases, and we may have continued incontinence. Of course, as long as the *sphincter vesicæ* remains normally acting, a weakened or paralyzed *detrusor* muscle will cause partial or complete retention of urine, as the case may be.

I think it likely that incontinence may follow long-continued distention of the bladder, as indeed retention may supervene upon voluntary retention, owing to lack of opportunity to void urine or to a false modesty. Here is a point of warning to those who do not promptly attend to the calls of nature.

Dilation of the stomach, distention of the bladder, the overstretching of any dilatable organ, lessen its normal elasticity and response to legitimate functioning.

### Incontinence of Urine

In paralysis of the bladder-sphincter, incontinence will take place when pressure becomes sufficient to affect the exit orifice. A slight control may be exercised when the patient is awake, but, during sleep, there is not this inhibition, and we have incontinence. In women with such weak control, we find a loss of urine over a sudden jar, shock (such as a misstep), sneeze, or bad news. In men, with the longer urethral channel, we do not often find the sudden loss (unless complicated by seminal discharge), but a dribbling.

In spasm of the sphincter, with forcible retention of urine, we have similar causes acting, but, as a rule, the retention is of short duration and can be controlled by action of the will, suggestive measures, or external application of heat in liquid form. In severe cases with bulbo-urethral and anal pain, we must deal directly with the sensor-reflex center. Fussell says: "Rare in women except after childbirth or operations near vicinity of bladder. Women are very susceptible to suggestion. Sometimes, a woman cannot urinate in the horizontal position. This should be remembered. If there is paralysis of the *detrusor* muscle, and the sphincter remains intact, there will be retention of urine. If, however, communication with the brain remains intact by an act of the will, the reflex contraction of the sphincter may be suspended and the bladder partially emptied by a straining effort, at least so far as pressure can be exerted on the abdominal muscles. Should the afferent, or sensory, nerves of the reflex arc be paralyzed, either alone or in conjunction with the efferent to the *detrusor*, the bladder will become enormously distended; but if the distention continue, a point is reached when the sphincter is paralyzed by overstretching; then incontinence occurs, and the urine dribbles away."

### Case Reports

Case 1.—Feb. 7, 1923. Mrs. K., Hawaiian, married, housewife, no children, aged 50. Called at 2 a. m., 25 miles away, to find patient suffering from a distended bladder from which no urine had been voided for 48 hours. Bowels constipated, pulse 85, temperature normal. Otherwise, patient in good health, with no history or evidence of venereal or other disease. Catheterized with soft-rubber instrument easily, removing 80 ounces of urine (five pints.) Urine itself normal in color, specific gravity, and chemical reaction. I placed the patient on light diet, gave salines, and 1/60 grain of strychnine sulphate, three times a day, continuing to empty the bladder twice a day until the 16th. On the 14th, and 15th, patient was able to pass a few drops of urine, and, a day later, she had recovered full use of muscles controlling bladder.

It is needless to say that aseptic measures were used in catheterizing, as to instrument, hands, urethral orifice, and that no infection resulted, the urine being on the last day clear and normal.

The only cause of the paralysis, so far as I could discover, was alcoholism, as the patient drinks heavily and, on the 27th, as the result of a fresh debauch, had a recurrence of the dysfunction.

Case 2.—March 10, female, Japanese schoolgirl, aged 8 years. Found her with distended bladder, having been unable to void urine for 24 hours. Pulse 110, temperature 102°F., with other evidences of slight cold. Urine normal, except a higher color, and more concentration. No albumin or sugar. Bowels constipated. Removed 30 ounces of urine with rubber catheter, giving treatment as indicated by the general disturbance.

No further retention, and child returned to school on the 13th. Cause of paralysis of *detrusor* rather obscure. Perhaps due to the disturbance of heat center in a susceptible child as we may have a reflex eclampsia in some children and not in others, under similar exciting causes.

Case 3.—Sept. 10, 1922, K. Hawaiian male, married, aged 55 years, laborer. Came into office at midnight, suffering from 12-hour retention of urine. Previous health good. No history of syphilis, gonorrhea, or genitourinary disease. Pulse and temperature normal. Re-

moved about 20 ounces of normal urine with soft catheter. Normal function next day, when patient returned to work.

History of alcoholism.

March 10, returned for catheterization during spree.

### Be Clean, Tidy and Orderly

Just here, under remarks on a simple operation requiring such careful asepsis as must be observed in entering an organ like the bladder, let me set down a word about order and cleanliness in the physician. We are told that "Cleanliness is next to Godliness", that "Order is Heaven's first law". But, so far as I have been able to judge, the relation is not clear. Some of my Godly friends are what a gentle euphemism might term untidy and, I am sure, if it does not exist there now, chaos *has* reigned in heaven.

That order, system, meticulous technic, as well as absolute, and fastidious cleanliness are necessary adjuvants to the physician's personal activities, is as certain as the truth of the dictum that he must mix his medicine with brains. And, I think with Dr. Dodson of Chicago that, in the selection of candidates for the study of medicine, consideration should be made of character and temperamental factors as well as of intellectual qualities; for, to a great extent at least, I believe, that a neat man, like the poet, is born and not made.

While I should not want to have even a physician obsessed by dirt on the brain or go about with the proverbial speck in his eye, one cannot err much either microscopically or macroscopically on the safe side in the practice of medicine, especially minor surgery.

In my own household, I am perhaps regarded as a crank on the subject of order and cleanliness, touching house, office, drugroom, tools, skin, hands, mouth, and in the manipulation that proceedeth thereto and therefrom. I cannot write unless things on the desk are where they belong; I cannot work unless the field is clear of every possible visible and invisible contamination. I can find a needed bottle of medicine with my eyes shut or in the dark.

I grant that this is nothing to blurb about but only a *sine qua non;* that it will not make a good physician and surgeon out of a poor one. Yet, I consider it worth mentioning even to a body of men as intelligent and neat as you are.

I once visited, in Florida, a young physician who had just graduated from a good college with high honors. He was said to be a brilliant surgeon, and he certainly lacked nothing in theoretical and tactical training. But, he was born untidy. Always the constituents of his office and drugroom, yes, his operating room, were strewn about in hurricane disorder. Not a bottle stood in its own place, tablets in open containers were disintegrating; corks lay around. Here were iodine stains, there ichthyol spots. Knives, probes, graduates showed signs of last usage. Uncorked bottles gaped in dust. Tobacco ashes and partially-burned cigarettes were evident on shelf and table. They were stuck under table and chair like chewing-gum in school rooms. I saw marks of a lunch or two in the emergency bag. Pocket-cases were filled with blood-stained instruments, scales green with verdigris from a recent measurement of sulphate of copper.

This brilliant surgeon should never have been allowed to graduate. He ought to have been a garbage scavenger or a drain trawler. Nothing could ever cure him of disorder and untidiness because he did not realize what dirt was, or that it was not in the nature of things, a molecular part of everything else.

Of course, that one trait ruined the man as a physician and surgeon. The last I heard of him, he was drawing a salary as government physician on some lone, isolated island to the Caribbean.

### Thyreo-Glossal Cyst

We are told that the hyoid bone is shaped like a horse-shoe, has no articulation with the skeleton, and supports the tongue. It is developed by five centers, one for the body and one for each of the four horns. In the embryological period, a duct extends from the base of the tongue through the hyoid to the thyroid cartilage. This may be and often is the site for congenital or implanted cysts or sinuses. The sinuses may open externally, usually in the median line of throat, or into the mouth, discharging a glairy mucus.

The closed cyst finally calls for relief and, in most cases, must be opened. This evacuation, however, does not cure the cyst which generally reopens, in a few weeks, with the accumulated fluid. The usual treatment is a surgical one—the complete removal of cyst and lining of duct, obliterating elements of recurrence. We are told by Foote that dissection must be deep enough to expose all abnormal tissue, both above and below the hyoid bone, if need be. This is easily done if the sinus be wide and patulous; if narrow and closed, even a well-marked cyst may be difficult to remove. Otherwise, through a free

channel, the rounded cyst is soon dissected out. A local anesthetic is generally preferred to etherization. If the bone has been perforated, the lining should be curetted away, also any necrosed portion.

"A guarded prognosis as to cure should be given", says one author. Dean and Gregg, who claim to have found no reported case of implanted cyst of the larynx, note one of their own in a married woman of 50. There was an arytenoid infiltration with vocal interference. Diagnosis—implanted epithelial cyst. New, who reports three cysts of the larynx, says that they may be located in any part of the larynx, the most common situation being the anterior surface of the epiglottis where the mucous glands are most numerous. The retention cysts, some as large as a hen's egg, are lined with columnar epithelium. The cyst-walls in the three cases were lined with fibrous tissue. Dr. New advises removal and cauterization, by the direct, indirect or suspension methods. A thyroidotomy may be necessary in order to get permanently rid of the embryonic cyst.

Dr. Chamberlain, in a recent issue of the *Journal-Lancet,* reports a case in an infant which from birth had a peculiar cry—a stridor on inspiration. Otherwise, the child was normal, with healthy tonsils and no adenoids. "A large, smooth-walled, rounded tumor with small blood vessels at its surface, was found. It was about 2 cm. in diameter, located on the right side of the larynx; a hypertrophied fold of mucous membrane from the left aryepiglottic fold caused the stertor. A long knife was thrust into the tumor, and this was followed immediately by a gush of brownish, viscid fluid, one or two drams in amount. The tumor had disappeared. It was impossible to dissect out the cyst wall. Four months later, there had been no symptoms pointing to a recurrence".

Case 4:—Hawaiian, female, aged 1 year. Child normal except that, since birth, there had been a sinus opening just above the epiglottis, in the median line, discharging mucus, slightly all the time and, at irregular intervals, larger amounts. There was a harsh, vibrating stridor on expiration, a sound like one hears in croupy children. I found the channel open for a probe which easily tapped the bone, and diagnosed the case as embryonic thyreoglossal cyst. The surgeon on Maui, to whom the parents took the child on my recommendation, did not think, for some reason or another that the case was one for operative interference at this stage, so I went on with general hygienic measures, carefully curetting the sinus, using mild injections of nitrate of silver, and Monsel's solution; but without much benefit, if any. I then tried injection of permanganate of potassium, at first 1:8000, afterwards increasing strength to 1:4000, and found the discharge lessening, until, in a few weeks, it ceased entirely with a closure of the sinus. There had been no recurrence of the trouble after two years, the external scar in median line being slight. I may say that I gave the child internally 2 grains of iodide of sodium twice a day, for some weeks.

Whether the injections closed the sinus, or aided the iodide, in causing atrophy and disappearance of the cyst, I cannot say. The desideratum, at any rate, was achieved.

In this case, the stridor occurred during expiration and disappeared with the cure, although, according to Kerley, congenital stridor occurs generally during inspiration and is due always to "bilateral abductor insufficiency".

### Ill-Directed Energy

While we as physicians and publicists are glad to see the aroused general interest in the physical welfare of children, are willing also to aid in the efforts made to impove the condition of boys and girls of all races in the schools, and are prepared to exercise tolerance towards those inexperts and the untrained whose very enthusiasm has led them into unscientific by-paths, we may well fear exaggerated emphasis upon a few cases of so-called abnormality, malnutrition, tonsillar and adenoid dyscrasias, and so on.

When even good movements become fads, taken up by overzealous and not always qualified persons, they are apt to lose direction by a weak left leg; some one phase is made the sole cause of all ills. Thus attention may be taken off more important morbid causes, and the root of the evil remains intact.

Some four years ago, I, myself, in a special leaflet, called attention to the menace of decayed teeth in school children, its frequency, and the possible results to physical and mental health.

We suggested the organization of tooth-brush brigades in the schools, and I agree with Dr. Fone of Bridgeport, Connecticut that it is high time to educate the children to the necessity of dental hygiene. I do now re-emphasize the importance of good teeth and voice my support of any movement to improve the condition so universal in our schools, but I find many other causes of bodily delinquency.

We have seen the pendulum swing to an

extreme in the various malnutrition campaigns, children sorted like potatoes by arbitrary technic of measurement, some being culled for an inch or a pound of delinquency.

In types of children we have seen evidences of malnutrition and lowered vital force by standards of determination which should have no general application—measurements of no value except as applied to individual cases in particular. The trouble has been, that the diagnosis of condition has gone into the hands of very good but very inexpert persons, nurses and others of the laity, when physicians alone should be the judges. This in regard to children varying in height and weight from average types, but still not in any way abnormal or in need of special treatment.

There are those, too, who, falling short of normalcy, have been classed as undernourished, underfed, and recommended for a more abundant and adequate diet. These have not been studied or examined by a qualified physician who, in many cases, is not supposed to be as well informed as the self-styled expert, and they pass on to a course of treatment perhaps positively detrimental to them.

### Harmonic Organotherapy

Organotherapy has opened up a large field for the investigation of altered conditions in children. It has called a halt to the hasty removal of glands as causative factors in disease and, since Selfridge and others have declared "the well-founded physiologic interrelation between the tonsils and adenoids and the ductless glands", demanding a studied therapeusis, we are getting more careful how we attribute one single dysfunction to a single organ gone wrong, or believe that the removal of one offending gland will cure the evil we have in hand. How many times such removal is not followed by any betterment in health, or by worse health, and having wasted much in getting rid of the wrong thing—in hanging the wrong man, as it were—we do not go forth blameless.

Do we know enough about anaphylaxis, the antibodies, status lymphaticus, the pituitary and its hormones, hypo- and hyperthyroidism and the many abnormal conditions resulting therefrom—to place socalled stigmata in children in the hands of those who have made no study of the human body?

Who but the most assiduous and conscientious among us should try to deal with matters underneath which may lie, like a smouldering crater, dyspituitarism, spasmophilia, status thyrolymphaticus, where the possibility that some missing hormone may account for our moron or defective child? Who but ourselves shall know how to apply artificially the elements which nature needs but has failed to furnish?

In this case, we are the "angels" on the edge of things, afraid to cross where others are stepping in with large feet.

### Hydatiform Mole

Case 5.—A condition which occurs about once in 2000 pregnancies and, according to Landis, results in the death of 13 percent of its victims, is perhaps worth while recording.

Mrs. F., female, Hawaiian, aged 46, mother of five children born at full term after normal pregnancies. No history of miscarriages or uterine dysfunction of any kind.

Found patient, now four months pregnant, suffering from labor pains with considerable hemorrhage. Abdomen was as large as in an ordinary, full-term twin pregnancy, and patient gave history of several hemorrhages during her present term, with irregular discharges of water and "queer lumps", undoubtedly cysts.

As the os was patulous with regular pains, interference did not seem necessary and, in about an hour, patient was delivered of a typical stem of cysts, averaging in size from a bean to a filbert, and containing a clear fluid.

There was much vascular tissue, with gelatinuous masses, blood clots, and other débris of myxomatous origin, the whole weighing twelve pounds. I found no trace of the fetus which evidently had been absorbed.

I may note that four months is a longer period than the classical allowance of two to three months for the expulsion of this mass of degenerated tissue. After controlling hemorrhage and quieting "after pains" which were severe, owing to the over-distended uterus, I curetted the womb, painted with tincture of iodine, and packed with sterilized gauze. The thin walls of the uterus in such cases would indicate unusually careful curetting, which I note. Recovery uneventful, and without any rise of temperature.

Without going into the embryology, the details of which may be found in any textbook on the subject, I may note that, in early pregnancy, before its own circulation is established, the embryo is nourished from the yolk by the vesicle called allantois. We do not know just how the growth of this organ is effected, but we do know that it supplies the amnion lying next to the embryo, and the chorion adjacent to the uterus, with elements of development. The transparent, osmotic amnion is made up of thin, epithelial cells, smooth, delicate, and

adapted to its protective function, being without blood vessels or nerves. The fact that the fetus is without nerve connection with the mother, held in its little ocean only by its placental cable, would indicate to physiologists at least, that prenatal mental impressions so dear to the laity, have no anatomical or physiological foundation; but, I presume, those who hold to the dusty theory might claim that such influences could act on the unborn child through the placental blood supply.

The chorion, with which we have to do, first envelopes the ovum, remains next to the uterus, is thick, opaque, and roughened by a plant-like growth of tissue called villi, rich in blood vessels, the ends of which enter the uterine decidua, carrying nutritious fluids to the chorion. The villi flourish until the embryo becomes a fetus, when most of them disappear, the remaining ones forming the placenta.

Being very vascular, subject to rapid growth and modification, these tissues, like others of similar nature, are liable to hyperplasia, abnormal determination and degeneration.

As we may speculate unscientifically or with plausible theories upon life itself and its origin, we have reached no demonstrable conclusion, and so we do not even know what determines sex, or at which stage of embryonic or fetal growth the important developmental bypath is taken. Nor, having at hand the histological constitution of the umbilical cord, and knowing its function, do we yet know how nourishment is carried from the mother to the child in the placenta. We believe, however, that the scheme is one of osmosis, and that the passage of the mother's blood is made through the villous spaces.

Supervening as they may, we have in our present exhibit a serious result of misdirected development. And there are others.

### Obstetric Difficulties

Adherent placenta may result from a penetration by the villi into the uterine sinuses. There may be perforation therefrom and rupture. Dorland claims that the malignant degeneration, called chorioepithelioma, or synctioma malignum, sometimes follows hydatiform mole, due to the retention of a useless layer of fetal cells, the synctium, which usually atrophy but, like several other remnants in the human body, by no means in "innocuous desuetude", assert themselves to the detriment of normal tissues whose guests they are.*

I may merely mention that Ayora in *Surgery, Gynecology and Obstetrics* for May, 1918, v. 26, pp. 568-9, reports a case of chorio-angiopagen, which, if not directly related to our case, is a degeneration of the chorion.

The following measurements up to 4 months, by Dercum, may determine one to decide when an embryo becomes a fetus:

At end of 1st month, 1 cm. or 4/9 inch.
At end of 2nd month, 4 cm. or 1 7/9 inches.
At end of 3rd month, 9 cm. or 4 inches.
At end of 4th month, 16 cm. or 7 1/9 inches.

### Uterine Casts

Case 6.—Mrs. S., Caucasian, aged 25 years, married 6 years, no children or history of miscarriages.

Slightly anemic, record of neglected constipation and, since puberty of painful menstruation with discharge at these periods of peculiar membranes and casts, concerning which no physician was consulted, the woman being informed by her mother that marriage would "cure" her. There was considerable leucorrhea at times.

After marriage, at 19, there was no improvement, and patient came to me because she and her husband were anxious to have children and thought that perhaps the unusual discharge had something to do with the sterility.

At three subsequent menstrual periods, I made a careful examination of the extruded products, finding shreds of membrane of different sizes and shapes on two occasions, and on one a complete cast of the interior of the uterus, whitish in appearance externally, the inner surface being reddish, smooth, with openings probably representing the utricular glands.

About two weeks after menstruation, patient was placed in Sims' left lateral position, a Sims' speculum and parallel dilator used to enter the vagina and uterus, the latter organ being carefully and thoroughly curetted with a Braun dull-edged douche curette. The uterus was then irrigated with a sterilized normal saline solution, mopped with a solution of iodine and ether, equal parts, and packed with gauze.

Salines for bowels as indicated, a tonic of quinine, strychnine and iron for two weeks, followed by Fowler's solution in increasing dosage for two weeks. This treatment was continued for two months.

There was less pain at the next menstrual period, but still some endometritic shreds. In the second menstrual period, there was a decided improvement, and the third came free from pain or casts. The sixth menstruation did not appear, the patient being pregnant

and, at full term, I delivered her of her first child.

We are told that this condition is likely to be taken for an abortion. I do not think that differential diagnosis would be difficult in such cases. There is usually a history to record, and the shreds or casts are characteristic. In any case, microscopical examination is definitive, as the utricular and interglandular tissue of exfoliative endometritis does not resemble that of the irregular decidual cells of pregnancy, nor are there evidences of chorial villi.

Care will eliminate exfoliative vaginal mucous membranes, and I do not know that any difficulty would be met by a similar treatment if the condition were one of blood or fibrous casts from the uterus.

A second case with less characteristic casts and more exaggerated symptomatology, was treated in the same way with similar recovery, except that the patient did not become pregnant.

**Mumps Complicated by Mastitis**

Case 7.—Uncomplicated mumps is not considered a serious disease, and probably is not. A sight of its victims, as with those of hysteria, hayfever and itch, seems to excite the risorious muscle in one's neighbors who on such occasions are seldom better than Job's comforters. We take the child with mumps out of school, put him to bed, give him magnesia or a Seidlitz powder, limit his diet to light foods excluding fruits and acids, telling the mother to keep the boy in bed until his fever is over, and in the house till the swelling is down, warning her for the other children that the incubation period is as long as three or four weeks, and advising her of the possibility of invasion of the testes or ovaries, as the case may be.

My note here is merely to record that B, male, aged 10, two days after swelling of both parotids, developed tumefaction of the left mammary gland, the swelling extending down all the way from neck, with some redness and tenderness of gland. Hot applications and iodine locally.

As may be learned by reference to clinical reports and textbooks, the complications may be orchitis, ovaritis, mastitis, urethritis, edema of the scrotum, adenitis involving salivary, submaxillary, inguinal and sublingual glands. Nephritis has occurred in one case of mine, and some authors report such serious complications as pericarditis, endocarditis, and pancreatitis, and indeed a mixed general pyemia.

The possible complications then make it well to treat the disease from its inception as a serious one and one that makes it incumbent upon the physician to remove the very general impression among mothers that mumps is a disease to be courted in early youth.

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While these notes may not be remarkable in any way, and the observations and inferences after all be only emanations from one mind, I submit them for what they are worth. Each physician comes upon his own series of diseases, anomalies and therapeutic results or nonresults. He checks off his own experience by that of other recorders, rather than by the exceptional case which his experience as well as his reading may disclose to him. But, the exceptional case, like the legal precedent of the lawyer, remains a valuable asset and often a guide.

*Carter speaks of "rests of fetal life", accounting for the development of adenomatous goiter.

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*"BEVERLEY ROBINSON was so great of attainments, so full of human love, so pure in heart, so liberal towards the faults and weaknesses of his fellowmen and so close to his God in his daily life that I am unable to do him justice in writing of his perfect life. I thank God that I knew him and that we loved each other as brothers."*

—DR. C. A. BRYCE.

# Ocular Manifestations of Syphilis

By H. L. WARWICK, M. D., Fort Worth, Texas

IN order to cover as much scope as possible in so broad a subject, I will confine myself to the symptoms and points of diagnosis, beginning with the lids and muscles of the lids and continuing on through to the retina.

### Lids

Syphilis of the eyelid may occur in any stage of the disease, and it is important here to distinguish chancre from beginning cancer. Chancre, in this location, causes an enlargement and eversion of the lids and is most often located at the inner angle. There is the usual enlargement of the postcervical glands, and a secondary eruption may or may not be present.

The difficulty in recognizing these chancres is due to the fact that an ordinary description applies only to genital lesions, and of course they differ in various parts of the body according to the character of the tissue in which they are found.

Macules, papules and pustules may appear on the external surface of the lids as elsewhere. Late lesions may occasionally form upon the lids and chancre here may be due to kissing by an infected person or to an attempt to remove a foreign body from the eye with the tip of the tongue, a filthy practice.

### Muscles

The muscles of the eye are the extraocular which consist of the four recti and the two oblique and also the levator palpabre superioris, and the intraocular which are ciliary and the sphincter of the iris.

The third nerve enervates all muscles except the external rectus and the superior oblique. The external rectus is supplied by the sixth nerve and the superior oblique is supplied by the fourth nerve.

Now, in a condition of ptosis, where the upper lid droops down over the eyeball and cannot be voluntarily raised, the levator palpabre superioris, which is supplied by the third nerve, is at fault and Keyes says "paralysis of the third nerve is almost the hall mark of cerebral syphilis, so common and so characteristic is it, whether occuring alone or in connection with graver lesions."

Complete paralysis of this nerve is readily recognized as the symptoms are characteristic. The upper lid droops down covering the eyeball and the patient tries to raise it but cannot. The eye cannot be moved except outward, which is done by the external rectus. The pupil is usually widely dilated and does not react to light or to accommodation, and distinct near vision is impossible due to loss of accommodation which is caused by a paralysis of the ciliary muscle. There is also a crossed horizontal diplopia.

Syphilis causes a basal paralysis. The lesion is located between the base of the brain and the bony orbit, and the lesion may be an inflammation or degeneration or by the pressure of gummata or periostitis. Basal lesions will affect more than one nerve and sometimes affects both sides at the same time, but I have never seen this.

Paralysis of the ciliary and the sphincter of the pupils, which are the intraocular muscles, is caused by syphilis more than any other disease. Tabes and progressive paralysis are responsible for some cases.

Another form of paralysis affecting these muscles is the loss of the pupillary light reflex, the Argyll-Robertson pupil; the pupil in this case does not contract when light is thrown into the eye and does contract with accommodation and convergence. The location of this lesion is vague, but is thought to be in the vicinity of the nucleus of the third nerve and is thought by many to be due to syphilis.

The tarsus and conjunctiva I shall only mention in passing, as syphilis here is uncommon. Tarsitis is usually syphilitic in origin and produces a great thickening of the tarsus owing to a gummatous infiltration. Chancres may develop on the conjunctiva and mucous patches may also be seen here, but it is not common.

### The Cornea

Interstitial keratitis is essentially a syphilitic affection and in ninety percent of the cases lues may be demonstrated; and, as it nearly always occurs between the ages of 10 and 18 years, it is due to hereditary and not acquired syphilis. Only in rare instances has it been found in adults with acquired lues.

The disease is nearly always confined to one eye. The general appearance of the patient, as a rule, is characteristic of the hereditary taint. The flattened thickened nose, with small fissues at the nostrils, scars about the angle of the mouth, pale and sickly faces with a senile look, enlarged glands of the neck all go toward making a diagnosis; and, of course, the Wassermann reaction—blood and spinal—will generally confirm it.

The appearance of the eye varies a great

deal. In the usual form, there is a marked ciliary injection, the surface of the cornea has lost its luster and there is a triangular opacity with its base at the sclero-corneal margin and numerous small opacities scattered about the cornea which later coalesce.

It is with difficulty that the pupil is kept dilated and the anterior chamber is deep. There is not a great deal of pain, but photophobia and reduced vision cause great anxiety on the part of the patient. Ulceration is rare. A perfect return of the transparency of the cornea seldom occurs, and several months pass while the disease is in progress. There are many other forms of keratitis due to injuries, infection, etc.

### The Iris

Here inflammation is most common, and is attended by enormous dilation of the blood vessels in the affected and in the adjacent structure, and show externally by a peculiar deep ciliary injection. The functional activity of the iris is supended and its color changes. Adhesions form on the posterior surface of the cornea or the anterior surface of the lens which, if left, limits the movement of the iris greatly and changes the shape and size of the pupil.

The causes of inflammation of the iris is due to syphilis, rheumatism, absorption of toxins from pus pockets in tonsils or sinuses or from pyorrhea alveolaris.

The two forms of iritis that interest us are simple plastic, the most frequent, and serous. Acquired syphilis is said to be responsible for from 30 to 80 or even 90 percent of all cases of the plastic form. The symptoms are marked ciliary injection, haziness of the aqueous, discoloration of the iris, a contracted and immobile pupil and adhesions of the iris to the lens capsule. The pupil appears to be rolled under when examined with a strong lens.

The course may be acute or chronic. It may run its course within a few weeks with a total absorption of the exudate and return to normal. These cases are rare for, more frequently, adhesions or opacities are left upon the anterior capsule of the lens. These adhesions limit the movement of the pupils and are a source of constant irritation and a tendency towards recurrence upon the most trivial cause. Total synechia or occlusion of the pupil can or may result.

### Serous Iritis

The iris appears swollen. Small yellow nodules are seen or the entire iris may look yellow. The margins of the pupil are bound firmly to the lens capsule and the congestion is intense. Occasionally small vessels rupture and there is an extravasation of blood into the anterior chamber. Pus cells may appear and a hypopyon will form in the anterior chamber. Pain is intense, with photophobia and lachrymation. The later stages of syphilis are responsible for this condition as a rule, but gonorrhea and rheumatism are said to also induce this form of iritis.

### Choroiditis

Congenital or acquired syphilis is the most frequent cause of choroiditis. The condition is characterized by exudation and hemorrhages into the choroid. When it is absorbed, the diseased areas are replaced by connective tissue and appear upon ophthalmoscopic examination as white shiny spots. It may occur with diseases of the retina or iris, or exists independently. The vision is rapidly lowered and the affected areas are permanently impaired.

### Retinitis

Retinitis is caused, most frequently, by albuminuria and next by syphilis and then the various forms of intoxication.

Either hereditary or acquired syphilis will cause retinitis. The objective symptoms are hyperemia, exudation as a grayish veil over the retina and brilliant, glistening white spots seen about the periphery of the fundus. Vision is diminished, night blindness is present and there is a persistent dazzling brightness, even in the dark.

Vision may be improved under proper treatment, but is rarely ever restored to normal. There is a great tendency to recurrence and it may finally result in blindness.

I realize that I have covered this intensely interesting subject only in a most general way, and each section of this paper could be further elaborated upon and again presented to you in a manner which its importance demands.

Look carefully at the pupils of the patients that come to you; for it seems to me that here may be found the first ocular manifestations of syphilis.

# Glioma of the Optic Nerve

By HENRY R. LESSER, M. D., Toledo, Ohio

THE extreme rarity of this condition is the reason for the following presentation. Doctor Verhoeff, at the meeting of the American Medical Association, in 1921, reported eleven cases which he had collected, only three of which had been seen at the Massachusetts Charitable Eye and Ear Infirmary in twenty-seven years.

The patient, Miss W. G., a girl of fourteen, was first seen on March 28, 1924, at which time there was a protrusion downward and outward of the right eye which "made her look queer". This had been present and increasing for some six months. Further examination revealed little loss of motion; vision reduced to light perception and tension minus two. Ophthalmoscopic examination showed papilledema of about two dioptres, and a small detachment above, but no intraocular neoplasm. At no time was there any pain. The diminution of vision antedated the protrusion, but the patient could not tell by what length of time.

X-ray pictures made by Dr. Ralph Deming revealed nothing but the fact that there was no bony involvement. This was in itself important.

All things considered, I gave it as my impression that we were dealing with a glioma of the optic nerve, originating in the sheath, very much like Dr. Verhoeff's cases referred to above. Operation was advised and refused.

On June 22, 1924, the patient returned, the condition having progressed to the extent that vision was nil; the protrusion so marked that the lids could just be forcibly closed, and a mass could, I thought, be palpated behind the upper nasal side of the globe.

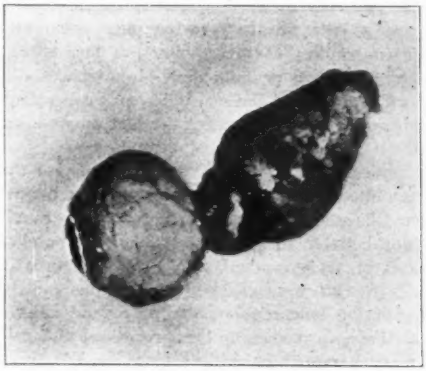
This time, operation was decided upon, and on June 25 the globe and tumor (which confirmed my original impression) were enucleated en masse through the conjuctival route. A radium tube with 50 milligrams was inserted by Dr. John Murphy and removed after twelve hours, making a total of 600 milligram hours.

Recovery thus far has been uneventful.

The glioma here pictured measured thirty-five millimeters in length and twenty millimeters at the widest point.

The pathological report is appended, and acknowledgment is here made of my indebtedness to Dr. Thos. L. Ramsey for the interest he has displayed.

Of the ultimate prognosis, little can be said. Referring again to Doctor Verhoeff's report, it is stated that recurrence in the orbit has never been recorded. On the other hand, the involvement of the pia speaks for possible intracranial extension and, whether or not the radium has taken care of that, time alone will tell.



**Macroscopic Examination**

The globe is normal with the exception of papilledema of the disk. There appears to be an area of pathological retinal detachment about 1 cm. in diameter at the superior pole of the globe. Several other detachments are seen which are from handling during and after operation.

The nerve stem as it passes through the sclera is about 3.0 mm. in diameter and begins to enlarge immediately behind the globe.

The tumor is ovoid in shape, its greatest diameter being 20.0 mm. and extends backward 35.0 mm. being cut off at this point while its diameter was still about 6.0 mm.

Longitudinal section through the tumor shows it to be entirely intradural. The tumor has broken through the pia in many areas and invades the arachnoid and subdural space. Several small cystic areas are seen in the arachnoid and are filled with a hemorrhagic exudate. This portion of the tumor is softer than at the center and is somewhat boggy to palpation.

The dura over the main portion of the tumor appears thickened and shows congestion of the surface vessels. The dura shows very little invasion and has not been broken through.

The nerve stem at the lamina cribrosa is 2.0 mm. in diameter, enlarges abruptly and at

center of tumor is 10.0 mm. then decreasing to about 4.0 mm. at resected end.

**Microscopic Examination**

Sections were taken through the entire length of the tumor from disk to the resected end. Hematoxylin, eosin, van Giesen's and Mallory's neurogliar stained sections were studied.

The tumor is made up, for the most part, of a finely reticulated neuroglia syncytium. There are many elongated spaces running in the direction of the long axis of the tumor and are situated between what has apparently been bundles of nerve fibers; a fine fibrous septae is still present along these spaces.

The nuclei of the neuroglia cells are round, ovoid or triangular in shape and surrounded by a variable amount of cytoplasm.

In other areas the cells assume more of the spindle-cell variety, are more closely packed and have coarser neuroglia fibrils. The transition between these areas and the smaller glial cell areas is gradual. The coarse neuroglia fibrils run somewhat irregularly but mostly with the long axis of the nerve and appear to have formed near the surface of the primary nerve fiber bundles.

Vacuolization of the glia cells is present to only a slight degree and no cystic spaces are formed. Cytoid bodies are very few in number and are all seen among the coarser neuroglia fibrils and are in an early stage of development. Blood vessels are few in number and are relatively small.

The epineural subdural portion of the tumor shows a very irregular structure composed of glia syncytium and areas of spindle cells with the coarse neuroglia fibrils. Small cystic areas are present in the proliferating arachnoid. Many of these spaces contain a hemorrhagic fluid.

Blood vessels are numerous and show slight thickening of their walls and apparent chronic congestion. No cytoid bodies are present in this portion of the tumor.

Proliferation of the glia syncytium is present to the resected end of the nerve, there being no normal nerve tissue present. The rapid approach toward the normal diameter of the nerve at this part indicates that only a very slight involvement of the intraosseous segment was probable.

**Diagnosis**

Mixed finely reticulated and spindle-cell type glioma of optic nerve.

Finely reticulated glia syncytium predominating.

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## My Prayer

*TO live not long but well, I pray,*
*Clean, upright, honest, and sincere;*
*Let me be big in little things,*
*And brave when trials come.*
*Let me neither condemn nor scorn my weaker brother,*
*But always know he does the best he can;*
*And that none but God*
*Can completely understand.*
*If sickness, failure, or suffering should be my fate,*
*Give me courage to meet*
*Each, as a soldier, bravely;*
*And when the last Great Adventure comes,*
*May I go smiling.*

—SCOTTIE MCKENZIE FRASIER.

# Surgical Seminar

Conducted by GUSTAVUS M. BLECH

### A Personal Request

IT is requested that all interested in the Seminar, especially those readers who have not contributed to this department, send me a post card or note, giving me their addresses and, at the same time, replying to the following questions:

1.—Do you consider the method used in the Seminar of practical value?

2.—If so, do you believe that this method extended to cover internal medicine and the recognized specialties or departments of medicine would prove of practical interest?

3.—Do you believe the method has defects? If so, please state them.

4.—If you have any suggestions to enhance the value of the Seminar, please state them.

It is hardly necessary to add that the information sought is for my personal benefit and not to be used for publication. I also request that such correspondence be sent direct to me, at 108 North State St., Chicago, to insure early delivery.

### Solution of Surgical Exercise No. 2

*Recapitulation.*—The problem, published in detail in the July issue, concerns a man who has been shot and who is bleeding profusely from the intercostal vessels, the missile having entered between the sixth and seventh ribs of the right side.

The requirement calls for the control of hemorrhage under emergency conditions, that is without any other facilities than are available with a few instruments and dressings, as usually carried by physicians in their handbags.

### Solution by General George Acheson, Kingston, N. B., Canada

After sterilizing the skin surrounding the wound as thoroughly as possible, under local starting from the bullet wound, cut down on anesthesia, produced by injecting the area with whatever local anesthetic I had in my case, (e. g., cocaine, procaine, butyn.), I would and freely expose the lower margin of the sixth rib. The bleeding vessel will probably come into view and can readily be secured by ligature or torsion. If the rib has been splintered, as is probably the case, loose fragments should be removed and, if the hemorrhage is thus controlled, the wound may then be sutured and a dry sterile or antiseptic gauze dressing applied, to be held in place by strapping or a bandage. Strict rest in a recumbent position is to be enjoined, and the patient carefully watched for further symptoms of shock or internal hemorrhage.

It may be that the trouble is not with the sixth rib and its intercostal artery but with the seventh; and it may be necessary to exsect a portion of this rib before the bleeding point can be secured. With the instruments available in a surgical pocket-case, this may not be possible; but, it is possible to control the hemorrhage by pressure applied from within the pleural cavity. This can be done by pushing with a large blunt probe, the center of a piece of sterilized linen, five or six inches square, along the track of the bullet between the ribs into the pleural cavity, so as to form a pocket; then, pack into this pocket sufficient sterile gauze to make a pad too large to be forced out of the intercostal space. By traction on the linen outside, sufficient pressure against the internal surface of the rib can be obtained on the torn vessel to arrest the bleeding; and the pressure can be continued by fastening down the edges of the linen, or by tying a ligature around it. This, of course, is merely an expedient in case the bleeding vessel can not be ligated or twisted.

### Discussion by Dr. E. C. Junger, Soldier, Iowa

A bullet-wounded man is a rather *rara avis*, surgically speaking, with us, here in Iowa. Hence, I cannot discus this problem from the standpoint of actual experience but rather from a purely theoretic point of view; that is to say, I cannot consider what I would do were I to confront a situation as described in Surgical Exercise No. 2.

Patients in shock due to loss of blood or other causes producing sudden low blood pressure, are rather good subjects to work on,

since they are in no condition to resist the surgeons efforts or to interfere, at least not annoyingly, with his ministrations, and outsiders, friends or members of the family, are too frightened to offer suggestions or advice. It is up to the surgeon to intervene energetically and everybody recognizes his authority.

The thing to do that suggests itself almost automatically is to grasp the intercostal vessels with one or more hemostats, or to ligature them, if need be, by passing a threaded curved needle under each bleeding vessel and control the hemorrhage by ligating the tissues in the domain of the bite, the knot or knots, naturally, to be forced down upon the tissues.

The next procedure to be followed is the administration of morphine, gr. 1/4 and atropine, gr. 1/120, hypodermically, if need be, by proctoclysis or transfusion of normal saline solution as measures to overcome the acute anemia.

**Discussion by Dr. J. O. Rush, Forrest City, Ark.**

Under the conditions as they appear to the writer, the procedure would be to cut off the clothing of the wounded man to expose a wide field, to cleanse the wound with a 5- to 10-percent solution of iodine (alcoholic), to cover the wound with sterile gauze and over this sufficient cotton to produce firm pressure over the wound where the dressing is held down by adhesive strips. The hypodermic injection of 1/4 grain morphine and 1/150 grain of atropine is the next step.

The reason for this simple procedure, especially in gun-shot wounds seen in the south, lies in the fact that, as a rule, such injuries are sustained during the night with the missile, being a jacketed one, producing a clean cut wound.

The fact that we face profuse hemorrhage and shock would indicate that the hemorrhage is external in source, for in pleural wounds the site of entrance would be successfully plugged by clot.

The artery producing the hemorrhage is between the intercostal muscles and, as the one on the right side is larger than the corresponding vessel on the left side, the affected side of the chest should be firmly strapped.

The hypodermic injection suggested above has a two-fold purpose; namely, it is one of the most powerful means of combating shock and the surest to aid the well-being of the patient.

The medication, augmented by the appreciation that he is surrounded by friends away from danger, and in the care of a professionally trained man, makes for lessening of fright and for increasing moral courage. I have been fortunate in that I have treated many wounds of the character given in the problem. The results have been gratifying as far as the immediate consequences of the treatment are concerned. Any fatalities which I observed were invariably due to complications which developed some time after the patients had reacted from the primary shock.

**Discussion by Dr. J. G. Amthor, Sioux City, Iowa**

The condition of the patient presented in Surgical Exercise No. 2 is such as to warrant the statement that it would appear to be a needless waste of time to attempt to control the hemorrhage by merely bandaging the chest.

The more rational procedure would be to disinfect the area concerned with tincture of iodine and to pack the wound, with iodoform gauze. Gauze impregnated with 5-percent iodoform, as found on the market, seems best for such work.

A dry compress placed over the wound and strapped into place by adhesive tape sufficiently taut to limit the motion of the affected side, will prove of great value for obvious reasons.

I further suggest the hypodermic injection of 15 minims of a solution of adrenaline chloride (1:1000) and the administration of morphine, also by the hypodermic route, in the event excessive pain calls for such treatment.

The above is purely a first-aid procedure. It is hardly necessary to add that the patient should be removed to a hospital with a view of facilitating more radical work, should this prove necessary.

**Discussion by Dr. Albert A. Davis, Port Angeles, Wash.**

The only way to control external hemorrhage is by compression, ligature or forcipressure.

I would enlarge the wound sufficiently to reach the parietal pleura, and control whatever source of hemorrhage presents itself during the procedure in the usual way.

It must be recalled that, if the visceral pleura or the lung itself has been injured to an appreciable extent, the patient is sure to cough up blood. In the event such is the case, rest and the administration of pituitary extracts, calcium chloride, emetine hydrochloride, strychnine and atropine, as well as the injection of serum, etc., are decidedly indicated.

Expectant treatment, however, has often led to regretful consequences, and nothing is so assuring as to open wide enough to see what

you are doing and to work properly. Drainage of the wound with the application of wet dressings, which should be kept wet, is of paramount importance.

The patient, as given in the exercise, is going to die unless aided quickly and properly. Any expedient is warranted to reach the source of the hemorrhage—gently, if possible, and forcibly if need be.

**Editorial Comment**

I presented the above surgical exercise solely for the reason that the control of hemorrhage of intercostal vessels is not as easy a matter as that encountered in more external wounds, and I was anxious to impress upon the readers of the Seminar the technics of controlling intercostal hemorrhage. But, the discussions have gone a bit beyond the scope originally held in view, and I am glad of it.

As Doctor Rush points out, such wounds as described in the exercise are frequently encountered in civil life. Wherever men have access to firearms, and especially pistols and revolvers, there physicians are likely to encounter gun-shot wounds.

In large cities, general practitioners seldom get a chance to render first aid in serious gun-shot wounds, for reasons which are not here enumerated; but, in the smaller localities, where hospitals are not completely under the control of staffs, any practitioner is likely to come face to face with gun-shot wounds unexpectedly and it is essential that he know the indications and contraindications of radical procedures.

Before proceeding with the technical discussion, it is of some importance to remember that, as the problem was presented, you were to control the hemorrhage upon arrival at the patient's side with the materials usually carried in your bag, because the patient showed evidence of shock.

Under such conditions, major operations are not practicable. It follows that attempts at exposing the pleura, resection of ribs and similar procedures can be dismissed from consideration. Intercostal hemorrhages, while serious, are seldom fatal, at least not in the clean wounds produced by modern firearms, even at fairly close range.

The simpler methods of controlling hemorrhage, such as compression, tamponade and forcipressure, would suffice even in this class of injuries, were it not for the narrowness of the wound channel and the inaccessibility of the vessels. The rigid thorax does not lend itself to deep work, except when the field is exposed, and this is what must be avoided.

The simplest and surest method of control of intercostal hemorrhage is one given many years ago by Langenbeck, and which General Acheson has given in his discussion.

I only desire to add that Langenbeck has advised that, after the "pack" formed by the gauze and the gauze pieces has been pulled up from within against the ribs, a few pieces of gauze, as used to wipe away blood, or perhaps a narrow strip of gauze, is again placed with some force into the dressing, and now the dressing is tied over the external packing. In this manner, compression is had on the vessels from within the wound, in the narrow wound channel and externally, absolutely insuring arrest of hemorrhage.

The palm, therefore, goes to General Acheson today.

My friend, Doctor Junger, betrays surgical intuition, but control by suture is a difficult procedure because of the character of the wound. Langenbeck's technic makes any instrumentation superfluous.

Doctor Rush, whom I welcome to our family, has the advantage of actual experience. I have purposely avoided any allusion to war surgery, since conditions at the front are not identical with those encountered in civil life; but, I can say that I have seen five cases of gun-shot wounds of the right chest, (1 suicidal, 1 accidental and 3 by housebreaking burglars) and I have not lost one, though, in one, a hemorrhage gave me considerable trouble for several weeks, and yet in neither did I do more than the Langenbeck "pack" plus tight bandaging plus rest in the semi-erect posture plus morhpine.

The discussions by Doctors Amthor and Davis are interesting in the light of what has been said, and I only desire to add that I have another letter in my possession from a colleague in Ohio, who asked me not to publish his name. He had a case with prolapse of the lung through the wound. After washing away every particle with saline solution he pushed the lung into the wound. The patient had a long siege of it but, finally—and, I may add, fortunately—got well.

Now, when we have a large wound of the chest produced by any weapon in which lung tissue has prolapsed, we ought to thank our stars for such a favorable accident. The lung is tamponading the wound! What better situation can we wish? What is more, keep it in the wound by one or more silk sutures! In such a case, a curved needle threaded with silk is the best friend available.

I am in receipt of a few letters which it would be interesting to publish were it not for the fact that discussions come a bit post-festum.

After a solution of a problem has been published, interest in it can be aroused only by something entirely different from what has been published before.

I acknowledge a letter from Dr. Frank M. Bleakney of Grove City, Pa., who discusses problem No. 16. Well, the woman left home cured long since and the diagnosis is no longer uncertain.

The doctor is requested to secure the copies concerned, as I have no connection whatever with the commercial side of the journal.

I am also very much pleased with a letter from Dr. J. Paul Jones of Camden, Alabama, who sends me the details of a case of pneumonia which simulated appendicitis. He saw the case shortly after our problem on this subject appeared and was on his guard!

It is pleasing to any one to know that his labors bear fruit.

I am indebted to Dr. W. Turner Eikner of Sidney, Nebraska, who discusses our first surgical exercise and recommends benzyl benzoate. Doctor Davis, who participates in the discussion published above, prefers gelsemium, lobelia and atropine to surgery in urinary retention. This case, too, is closed, but we may have occasion to reopen the discussion at some future time, and I am asking the gentlemen to keep watch on us.

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I have been out of town for several weeks and, as the Seminar had to be ready for the printer within twenty-four hours of my return to Chicago, I have had not time to write Doctor Hamner, but he presents for diagnosis two cases, which I submit within the hope that they will elicit a free discussion.

**Case 1, by Dr. S. C. Hamner, Gantt, Ala.**

You are called to see a boy, about 14 years old, who has not passed urine for 12 hours and is in great pain.

The patient has had the usual diseases of childhood and, except for a slight blow in the right inguinal region which resulted in an abscess about six years ago, his history was negative. The abscess subsided without incision.

Two days ago, the patient began to complain of pain and tenderness in the region of the bladder. Examination shows a temperature of 101°F. with a pulse of 139 regular in rhythm and respiration 20. The patient's face shows anxiety. There is swelling of the abdomen, tenderness over bladder and inability to void urine, some nausea and vomiting. What urine was obtained contains albumin and many pus cells.

Doctor Hamner desires not only the diagnosis but the treatment in this case.

**Case 2, by the Same Contributor**

Mrs. C., aged 32, married, mother of two children, youngest 2 years old. Family history negative.

Past history: Abortion six years ago. Appendectomy was performed in 1920, pyelitis a year ago lasting about three weeks. The patient claims to have had eczema at about the same time which lasted about five months.

Present history: A week ago, immediately after dinner, without any known cause, the patient had pains "all over," constipation, fever at night, severe crampy pains in left leg and arm which, however, are not painful on motion. Menstruation, which has always been regular until about two weeks ago, appears scantily, with pain and of dark color. The patient complains of a choking sensation in the throat and chest, looks very sick, tosses from side to side.

Examination shows: Temperature 104°F., pulse 100, respiration 20, tongue coated, skin sallow, lungs, heart and abdomen are negative except for a slightly enlarged spleen. There is no history of chills, the skin shows no rash. Subjectively of interest are: slight nausea, thirst, severe pains in left arm and shoulder and left leg, choking sensation in the throat.

Dr. Hamner desires the diagnosis of this case.

# Good Medicine

**Let us learn as we go, but not forget what we know**
**Conducted by GEORGE H. CANDLER**

## Amen!

GOD of our Fathers! Grant that we
Become not slaves to BIGOTRY.
Make us to see that tho' roads run
In diverse ways, the goal is one;
That all thy people should be free,
*As their Light leads,* to worship Thee!

FATHER of Freedmen! Stretch thy hand;
Replant the truth through this thy land,
That he who hates his fellow man
Comes under the eternal ban:—
That measureless, must be the loss
Of those who'd camouflage the CROSS!

SEARCHER of Hearts! That tolerance give,
Without which Freedom cannot live;
Dispel dissensions, plant the seeds
Of UNDERSTANDING midst all creeds;
Grant, God, Americans may be
True to their watchword, "LIBERTY!"

G. H. C.

## The Alienist

## vs.

## The Law of the Land

Good morning! Is your pineal gland calcified? Or, since you have unwillingly sat through the thirty-act farce recently staged "regardless of expense" in our central metropolis, do you find your falx cerebri ossified? Of course, there can be no question of the fact that you had more or less of a paranoid personality always. You *must* have played with Teddy Bears: you surely did have "phantasies" and your "split personality" has been evidenced scores of times. Only eminent Jurists, Criminal Lawyers (what a delightful double-edged term that is) and Doctors who have the *alias* "Alienist" are (presumedly free from these trifling mental defects. If you have done some particularly atrocious deed and are a cheerful self-confessed murderer, thief, pervert, liar and so forth, you may—if only you have money enough—get any number of these perfectly sane people to opine (or even swear) that you are not really *insane* but just possessed of a twisted psyche and are therefore fitted to be spoken of in rather endearing terms and chastised—if at all —very, very lightly.

When one thinks that a whole lot of us have been ambling along, abiding (as best we could) by the established laws of this land and civilization generally, it is, to say the least, slightly distressing to find that under certain circumstances those laws are merely playthings—balloons which may be tossed back and forth by skilled jugglers—ideals which can be provoked, by proper manipulation, to

perform hari-kari! One feels a pang—yes, many pangs—when he sees stout psychiatrists, lean endocrinologists, bald neurologists and amiable alienists generally, advancing for the trivial sum of $250.00 per day, carefully worded opinions which are intended to lead an estimable (and heretofore considered perfectly sane) jurist to stroke softly where, if he followed the Law of the Land in such cases made and provided, he would have to smite and smite hard.

Alienists are first of all physicians and the physician certainly should be above all things a humanitarian but he should not be either a fool or a hireling. He should know as much as there is to be known in this year of grace about the workings of the human body and mind but, knowing this much, he should not pretend to know things which are not known or twist facts to suit the fancies of a dollar-driven defense. Especially should he not do these things when the beings before the bar are more than ordinarily intelligent males, confessedly guilty of the most revolting, inexcusable crime of recent times. A murder, not done under illusion or delusion; a murder calmly calculated and craftily conceived; a murder of an inoffensive, helpless child by those in his own circle of friends; a murder almost unparalleled in its utter brutality and without parallel in the callous indifference of the pervert murderers—who serenely ate before proceeding to further abuse and ultimately strip and hide the body of their little victim! Most of the hideous and horrible details are too well known to need recounting; the facts that the murderers plead guilty and since have callously laughed at the Law and Society are also well understood.

What the ordinarily decent citizen—especially he who has children of his own—does *not* understand is how it could be possible, under the circumstances, to spend tens of thousands of dollars of the tax-payers' money —not to try these creatures of Evil but to counteract the elaborate effort of attorneys for the "defense" (as if there could be a real "defense") to show mitigating circumstances—circumstances which would compel the Judge (they did not dare a Jury) to pronounce a life sentence instead of the death penalty! And the entire "mitigating circumstances" were built up studiously by eminent alienists who must have known in their hearts that they were selling their wisdom to aid slayers of the most sickening type escape the fate ordained for such from the beginning. That spectacle is sad. It is also disturbing and certainly does not tend to make the Medical Profession occupy a more exalted position in the estimation of good common-sense citizens. The alienists dare not term their clients insane for equally able professional men would overturn their findings and a jury, of just ordinary paranoid proclivities, would most certainly hang them. So they quibble with words; they befog the issue and meanwhile TIME dims the picture of horror that the young Caligulas painted in carmine. Words and more half-understood or wholly incomprehensible words skillfully used will cause the wholly decent but only partly informed populace to falter in its judgment and ultimately withhold expression of absolute disapproval when the Balance of Justice goes down with a thump under the pull of money-manipulated MIND.

It's *clever*, of course, but if one is to admire the superlative craft and consummate cunning of the "Attorneys for the Defense" then one is almost apt to find himself admiring the crafty cunning and contemptuous disregard for the conventions of the criminals they defend! If *they* had "split personalities", suffered from mental disbalance and yet excelled in everything they undertook, what is the real moral condition of the men who defend their actions—or, if they deplore the *deed* (as they needs must), fight desperately to avert the consequences—for a consideration?

That is a nice question and in some form must be answered. If the Law of the Land is to be unheld—if red crimes are not only fastened to individuals but those individuals (possessed of every worldly advantage and driven by no stress save that of their own evil desires) confess that crime and rather glory in the cleverness of it (though bewailing the errors which led to discovery), then erudite and respected medical men should not be eligible for hire in their defense. If it is considered "perfectly proper" for such professional "experts" to cleverly contort Science till she seems to lean towards the side of the malefactor, then *anything* to beat the Law of the Land is "proper"—and our Law is not worth half a German pfennig and that is less than the widow's mite. If unspeakably atrocious homicides are not to draw the supreme penalty, what jurist will dare to pass the death sentence upon *any* murderer? Society would have to abolish Capital Punishment and establish a Twistatorium (with golf links and natatoriums) for gentlemen with split personalities, perverted sex ideas and a penchant for rapping simple paranoid plebeians over the head with daintily wrapped chisels and

then stuffing rags down their throat. And that is not all that was done in this case. The pliable public has not heard all the detestable details. They'd be nauseated for months if they had. Yet we hear one alienist speak of the prisoners at the bar as "Mr." So and So and "these *gentlemen*" and another use constantly the pet names the murderers were known by to their relatives and friends before the sheep's clothing was torn from them forever. There's method in that!

It does not take a highly-feed (not *fed*) "alienist" to point out that these wolves in lamb's wool are a great deal more numerous than is at all desirable—or comfortable. We have at this same time the spectacle of a young man slowly strangling an "ex-gal" (bearing his child) to death while a more recent sweetheart calmly drives the car. We have, too, a young bride of a few days shooting her husband to death because he made her jealous. We have an ex-light of the prize-ring, married eight, nine or ten times, killing the prospective next-in-the-ring and shooting up a few other decent citizens who incurred his enmity and—if they have the money—every one of these excrescences on Society can evidently secure the services of alienists who will calmly prove that *if* they did these things then they were "mentally sick" and should not be held strictly accountable! Crime we have always had and shall have. Insanity we have always had and shall have and no really sane man (if there be such) would wish to see the insane individual receive that punishment which should certainly be meted out to the reasoning criminal. But if there is to be one Justice for all—not some Justice and some sloppy or commercial sentiment—then every criminal, rich or poor, must under such conditions have his basal metabolism and nonprotein hydrogen content looked up and the harmony or dyshormony of his ductless glands definitely ascertained.

We have only to follow this theory out to its conclusion and we encounter the *reductio ad absurdam!* It appears pitiful to see really learned men make themselves absurd and it is more than pitiful, it is *terrifying*, to see them—for a fat fee and the publicity gained—deliberately attempt to make impotent the Law of the Land which is their and our only protection against the evil doer.

I have heard a great deal lately about the "sins of the fathers being visited," etc. If, as we become more enlightened, we tend towards excusing misdeeds because, *perhaps*, the parents or grandparents of the culprit were not quite up to standard, we are going to fall into a direfully deep pit. Notoriously wicked men have sired most estimable children. Cultured and God-fearing parents have produced offspring who were fiends incarnate. The slums, the tenement districts and the lonely farmhouse have produced criminals it is true but they have also produced some of our greatest, most noble citizens. Millions of men born without any advantages have lived decent lives; some of them have been models the best of us might copy. On the other hand, many of the most evil men who have lived or live today came of excellent stock, were reared in comfort or luxury and had educational advantages denied to others. Their parents may have been sound but they themselves preferred rottenness to sweetness and were *bad* because they set their minds to evil.

The mind of Man cannot be defined; the spirit of Man is quite beyond the power of Science to dissect and classify. The tangible we may, with moderate safety, analyze, but what finite being dare attempt to weigh the soul? That which is good is good. That which is bad is bad and is best removed from these premises. To accomplish this we have the Law and the alienist should not obstruct its orderly process.

The duty of the *physician* is to control, as far as he can, the bodily processes so that normal mental conditions may be more likely to obtain; to detect real mental disease or defects as early as may be, correct them where possible or take proper steps to segregate those who are not amenable to treatment. The so-called borderline cases—those wretched individuals whose condition becomes obvious only after an "explosion" which injures or destroys some one or some thing—should be regarded with pity but dealt with without sentiment, and justly. BUT every caution must be taken to prevent plain (but rich or influential) monsters whose mental acumen has never been questioned from being treated as mental invalids—*after* they have done murder and brought desolation into other homes. IF, I repeat, that can be done, then the Law of the Land is a thing of straw and Justice, as we have it, not only blind but deaf, dumb and paretic!

It is not a pleasant picture and it isn't conducive to one's professional pride to see the eminent alienists rally to the support of the high-class homicide when they would turn "thumbs down" for the slayer of the slums. If they say they "would not hang anyone

who kills because the mere fact that he killed proves he was abnormal," then I submit that these gentlemen themselves should be placed under observation—for the safety of Society generally. There is so much that is abnormal in the most normal of us and so much that is normal in the most abnormal (seemingly) that it behooves the best of us (i. e., those who have managed to keep our glands from making ghouls of us) to keep an eye on the rest of us!

What we seem to need is less laws, more *Law*, and a revision of our ideas of *order*. Also, more commonsense and decency and less "fall money". If all this sounds paranoic to you, you must at least have a "split personality." The alienists doubtless will say *I* have!

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Justice is truth in action—JOUBERT.

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Justice satisfies everybody, and justice alone.—EMERSON.

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Justice is the great end of civil society.—DAVID DUDLEY FIELD.

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Above all other things is justice; success is a good thing; wealth is good also; honor is better; but justice excels them all.—DAVID DUDLEY FIELD.

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God gives manhood but one clew to success—utter and exact justice; that he guarantees shall be always expediency.—WENDELL PHILLIPS.

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*Ay justice, who evades her?*
*Her scales reach every heart;*
*The action and the motive,*
*She weigheth each apart;*
*And none who swerve from right or truth*
*Can 'scape her penalty.*

—MRS. HALE.

# Let's Talk it Over

## Dr. Bryce's Talks

### Breaking-in of the Young Practitioner Under Difficulties

AN old doctor told me once, when speaking of the emoluments of the practitioner, that, whatever he might fail to get, there was one thing every doctor got and that, if he lived long in the practice, it was an asset worth having. That one thing was, experience and memories that one could always fall back upon, living over both pleasant and pathetic scenes. Fortunate, indeed, is the man who has reached a good age with a perfect memory for the events of his life from childhood on. He can entertain himself with many memory pictures that will surpass the most extravagant productions of the screen or the pen pictures of the novelists; for, verily, much of the truth seen by the observing physician is "stranger than fiction." Somehow, I am looking back myself tonight and am recalling some of my "thrills" in the budding stage of my practice, when I knew it all and felt much sympathy for the old fogies who were stumbling along in darkness; just as the younger set of today is sorry for me because I do not accept all the fool stuff ground out for medical gullibles by the press of the land.

As the dog days are upon us and the doctor's work is the heaviest, he requires light and refreshing diet and, likewise, restful recreation. Consequently, my "Talk" for this issue will certainly not require much cerebration on the part of the reader, and absolutely none on my part.

I am going back to the primer of practice—the "breaking-in" of the fellow who knows it all and finds out that he has it all to learn. It is the little things that stump us, make us ridiculous and mortify our pride more often than the weighty affairs of medicine.

#### The Wise Old Woman

The worst thing a young doctor has to contend with, in his early years of practice, is the wise old woman found in every neighborhood and whose special aim in life seems to be to meddle in the management of patients of young doctors. They never rest when a case of sickness is reported as being under the attention of some young doctor. They get busy at once and hurry to the bedside of the sufferer. There was one that fate had allotted to me, it seems, almost with my first patient. This woman was looked upon as an authority in the neighborhood in which I tried to commence practice. She was the neighborhood "Granny," old, ugly, tough and as mean and sour as a dyspeptic miser. It was an accepted fact that any *young* doctor who undertook practice in her territory had to have the endorsement of "Granny S.," or lose out. I am afraid I was born under a combative or belligerent star, for I did not take the advice of my friends and "go slow with Granny," but entered the lists with a full appreciation of my ability to practice medicine without the assistance or interference of any "granny," nurse or mother-in-law.

There are two classes of patients that will get a family panic-stricken very quickly if things look anyway unpromising, and they are, the baby with cholera infantum and the young woman in labor with her first baby. I had been called into several minor cases without encountering this old pest and thought she was going to keep quiet when I was around, but she could not suddenly surrender without a fight and I was just as determined to bully her "out of her britches" before I would let her run my practice.

However, it was not long before my opportunity came to see who was who; for, a young blacksmith came hurriedly one morning to my office and requested me to go at once to see his wife who, he declared, was "in great pains." I surmised what was the matter and took along my obstetrical bag and some chloroform and, on the way, I learned that it was her expected time, and I asked him:

"Who is there to wait on her and nurse her?"

"I have sent for Granny S.; she will look after her."

"Now, look here, young man; if you wish me to attend your wife through this case, that old woman must understand that she is only

there as a nurse to carry out my orders."

"All right, Doctor."

Fortunately, I got there first and at once prepared to hold the fort. I was conducted upstairs into the patient's room and found her mother and a very sensible looking negress sitting by the bed, apparently trying to cheer the patient up to meet the ordeal as she should. I found the young woman in good heart and in good condition and everything progressing favorably. I went to a window and sat down intending to observe the progress of the pains before deciding whether to leave for a short while or remain until it was over, when, without any knock or announcement, the door was opened and in came "Granny S." I could see at a glance that her word was law with the peasants of that neighborhood. The mother tried to introduce me, but the old hag merely honored me with a grunt and nod as she stood on the floor untying the strings of her long-eared bonnet and pulling off her coarse yarn gloves. Ignoring me entirely, she rolled up her sleeves and came to a table and greased her right hand plentifully from a saucer of lard that I had not seen until then, and started towards the bed saying:

"Honey, I'll jist edzamine you and see how things is."

"Hold on," said I, "I'll just edzamine YOU before you go any further."

I expected an outburst and was unprepared for the self-possession displayed by the old woman as she turned and calmly surveyed me from head to foot without saying a word. She was a perfect model of offended dignity and acted the part perfectly. I couldn't help admiring her gall and nerve, but felt that she had to fall and fall hard, if I ever expected to hold my head up again as an accoucheur of untarnished reputation. Reaching in my bag, I took out a bottle of germicidal mixture and, handing it to her, told her to "go out and wash your hands and arms and sponge them off with this. Confine your hair in some cap or wrap and put on a clean apron and come back ready to wash and dress the baby." She hesitated for a moment or two and then, handing the bottle back, said quite respectfully, "Doctor, you cannot teach an old dog new tricks," and, with a look of mortification on her face and trembling lips, she extended her hand and bade me goodbye. I started out to down this neighborhood boss of young doctors, but her closing act was too much for me. She had me whipped with the most powerful weapon a woman can yield—old age, helplessness and wounded feelings. I just put my arm around her and said: "Granny, you stay right here and help me out; you have the right heart in you." She gave my hand a good squeeze, slipped out of the room carrying my bottle with her and soon returned with sleeves rolled up, hands disinfected, a white towel wrapped over her hair and a long clean apron on.

"What next, Doctor," she asked.

"I guess it will be the baby next," I replied, and, in a few more minutes, I handed the little fellow to her with "here's your baby, Granny," and the old sport said "our baby". Poor old soul, she never forgot my *surrender* at a critical moment in her own *professional* career, and never again disputed my authority, but swore by me right or wrong and helped me greatly when I needed practice.

**The Patient-Stealing Kind**

The young physician often encounters his worst opponent within his own ranks and among the very class from whom he expects the most loyal support. I refer to the well-established older practitioners upon whom the young doctor calls when in trouble and to re-establish waning confidence in his newly-acquired families, when it is evident that they are growing uneasy with young sawbones at the helm.

There was one doctor that could come nearer being on both sides of the fence at the same time than any I ever met, and he did me out of several good families before I got the hooks into him. He was favored by nature with good looks, polished manners, good education and was a very accomplished physician. He was in his prime, had a fine practice, was well fixed financially, and was a social and *religious* pet among the people. All of us young fellows dreaded to have him in a case as a consultant and, somehow, he was suggested oftener than any of the other older men; also, he usually held the cases after we were discharged. The trouble was that you got out of a case and he got in absolutely ethically; in fact, almost with your consent.

I had two cases in which this fellow was forced upon me as a consultant and he treated me as nicely as any physician could have done, fully endorsing my diagnosis and line of treatment. Still, in both cases, I received a letter within two or three days, asking me to discontinue my visits and to send in my bill. It came to me that *my consultant* took these cases after I was discharged. Of course, the family had a perfect right to discharge me when they were tired of me, and any doctor had a right to take the case after my discharge,

but I had my thoughts about my friend. I was thoroughly satisfied that he was the instigator of my discharge from those two families, and related my experience to two friends, young doctors about my own age and also "breaking-in" like myself. One of them, Tom M., a strapping big fellow, had been treated in the same way by this same physician; and Jim. D., smaller, but game, had escaped up to that time but entered fully into our plan to stick by each other and break up this rustler's game.

In reasonable time, it fell to my lot to be called to another family who were "well fixed" and desirable clients. The patient was a boy about fourteen who had, what we called in those days, bilious remittent fever, which sometimes held a fellow down almost as continuously as typhoid. It was in the second week and I was beating his fever gradually down. The boy was really getting better by degrees but, one morning, as I was entering the house, I met a minister going out. I thought he bowed rather formally for a man of God and looked a little sneaky, but I also thought that I might simply be over-suspicious, and went on in to see my patient who had become really attached to me, in spite of my appalling doses of head-splitting quinine and bile-stirring blue mass.

As I entered his room and while he was alone, he drew my head down and said, "Doctor, I don't want any doctor but you, but *he* (referring to the minister) said they ought to call in Dr. C."

"Whom did he tell that to?"

"He told Mamma and Aunt Matilda."

"And what did they say?"

"They said they would tell you to call him in."

Just at this juncture, I heard rapid steps approaching the room and told him to keep mum and not let them know that he had told me anything. He gave me a very assuring wink, as his mother came in.

His mother belonged to that class of fanatics who would have followed her preacher plumb into the devil's den, if he had been headed in that direction, and she was trying to do the bidding of this drummer for Dr. C. and, at the same time, not offend me. She did not relish her task, but started in with:

"Doctor, don't you think Jimmy is very slow in improving?"

"No, Madam."

"Well, we would be better satisfied if you would call in another doctor."

"All right, Madam, who is your choice?"

"We prefer Dr. C."

"Very well, have him to meet me here at 10 o'clock tomorrow."

"You will have to write him a note to meet you, won't you, Doctor?" squeaked Aunt Matilda.

"Oh, no, he will come if you ask him to meet me."

The next morning, he met me with all the grace of a Chesterfield and, in the patient's room, he was politeness itself. After he had finished his examination and announced his readiness to retire and talk it over, I noticed Tom M. drive up and get out of his buggy and come to the front door. I requested the doctor to wait, as I had invited Dr. M. to see this interesting case with us and would bring him right in. He was unprepared for this move and showed considerable agitation, as I walked big Tom M. in and introduced him to the mother and "Aunt Matilda." The doctor knew Dr. M., for he had recently stolen a case from him as he had the two from me. I gave my friend the history of the case and my line of treatment and, after he had finished his examination, we retired for consultation. Our talk was most agreeable and both doctors agreed with me in every particular and suggested a continuance of my line of treatment.

I thought the moment had arrived to put the hook into my polite and complimentary consultant and head off another letter of dismissal from this case, and said:

"Gentlemen, under the circumstances, I would prefer that one of you should deliver our opinion to the family."

Good old Tom took the hint and said, "As Dr. C. is much the senior of either of us, I would suggest that we delegate that honor to him."

"All right, gentlemen, I'll just step out and give them our verdict," he said.

"Wouldn't it look better, Doctor, if we gave them a broadside?" queried Dr. Tom M.

"I don't understand you," he said.

"I meant that we *all* might step out *together*," said dear, old loyal Tom.

He was an oily old cuss and knew that we were on to his tricks, but he was tactful and just put an arm around each of us and marched us out and delivered as complimentary an opinion of both of us to the mother and "Aunt Matilda" as the English language would permit, adding an exhortation to stick to my directions.

As we all went out to the street to our buggies, Dr. C. said: "You fellows seemed a little distrustful of me. What's the trouble?"

I said to him: "Doctor, you do not have to ask us to explain our action. You have answered it yourself when you said we appeared distrustful of you. Do you remember the last two consultations we held, and that each one was followed with my dismissal and You were the man that took my place and held the case? You also consulted with Dr. Tom M. and his dismissal followed that consultation and you followed him and kept his case."

And Tom, whose indignation had gotten to the fighting pitch, let in and finshed up that meeting by saying: "We are tired of this game and if Bryce gets a letter of dismissal from this case you will get the damndest licking that I can give you!"

Dr. C. seemed greatly mortified and expressed his regrets that he had been not only misunderstood but insulted also. I prevailed on Tom to withdraw his remarks, and we all shook hands and parted, but we broke one doctor of a very bad habit.

We passed him around among the younger set. Every one of us refused to meet him when he was suggested as a consultant and, finally, we drove him out of the city for want of patronage.

**Paying Under Pressure**

There lived, fifty years ago, in Manchester, a suburb of Richmond now called South Richmond, one of the most picturesque and interesting characters that ever adorned the Virginia profession. The nearest I shall come to telling his name is, to say that he was the surgeon to Mosby's celebrated band of Confederate guerillas, whose name was a synonym for dash, daring and swift retribution.

The soldiers of the south had returned to their homes and were trying to adjust themselves to the changed conditions of a new citizenry—carpet-baggers, scallawags and suddenly-freed negroes; and, at this stage, our old war doctor opened an office in the town of Manchester, where people did as they pleased and answered to the law afterwards, if they were ever caught. Dr. M. was a well-qualified physician and fearless surgeon as well as a fearless man, and he had some other qualifications that might not have been countenanced by his pastor, but served him and the community well during those perilous times of reconstruction. He tied his old war-horse to the hitching post in front of his office. There was a bullet hole through his charger's right ear and the wooden pommel of his McClellan saddle was partly shattered by a bullet from one of Sheridan's raiders. These tokens bore strong evidences of the character of the man riding that horse, and each vest-pocket bulged considerably with what was said to be a pair of wicked derringers. He was an inveterate poker player, not afraid to bet his last dollar, a game loser, and he would collect, if necessary, at the point of his pistol when he won, if any objection was raised by card sharps. He hated the Yankee scallawags who flooded the south looking for pickings from the federal appointers to all manner of picayune jobs and what they could fleece the ignorant negroes of.

There was one thing he would not stand for: that was, any impudence from any of the recently emancipated negroes, and some were very offensive in their conduct towards white people who allowed it. I remember being in the doctor's office, on one occasion, when a very important negro man walked in and stood on the floor with his hat on and awaiting the doctor's recognition as he was finishing the direction of a letter. The negro's general attitude was one of studied impudence and defiance. I knew, trouble was coming. I saw blood in the doctor's eye, as he surveyed the darkey, and when he swelled to the exploding point, instead of drawing his derringer he reached for his old cowhide riding whip and said: "Take that hat off, you d——n black scoundrel," and the negro suddenly forgetting his fifteenth amendment rights, said: "Yessah, boss," and snatched it off. "Now, what do you want in here, anyway?" asked the doctor savagely.

"I camed in here to pay Aunt Nancy's bill whar she owe you."

"W H A T ?"

"I comed to pay Aunt Nancy Whitlock's bill."

"The hell you did," exclaimed the astonished doctor. "Here, sit down, my boy."

"What is your name?"

"Jim."

"Here, take a chair, Jim, how are all?"

"Dey is all pretty fair, and here is nine dollars Aunt Nancy say she owes you."

The doctor had more money than he had seen for a month, and, giving Jim a receipt and thanking him invited him to the sideboard pointed to the decanter and said: "Jim, try something, it will remind us all of the good old times." They shook hands and parted with perfect friendship. *Jim did not replace that hat on his head until he had cleared the doctor's door.*

The truth is: the relations between the negroes and the whites of the south have been greatly misrepresented by politicians and

fanatics who really know nothing of what they write. We owe the negro much and there is no stronger friendship anywhere than there is between white and colored who are to the manor born down in "Dixie."

The doctor had a healthy hatred for an army sutler who had drifted into Richmond with Grant's army after the surrender and located in the county about five miles from his office. It seems that he was instrumental in getting the doctor fined for some small offense when tried before a scallawag magistrate's court, and he never forgot it. One hot afternoon, in August a messenger rushed into the doctor's office and asked him to hurry out to see this Yankee sutler, who "couldn't shet his mouth." The doctor sent for me and said he wanted me to go with him as he felt that the ride would do us both good and he might need me. On the way, he confided his suspicions that the fellow had a dislocation of the lower jaw and that he was going to get even with him, too.

As we neared the house, we saw him sitting outdoors on the shady side of the house his wife keeping the flies away from his open mouth with a peach tree bush in one hand and a palm-leaf fan in the other. Her face was livid from exertion and his was red from exhaustion. As soon as we arrived the sufferer began to groan and point to his jaw, trying to talk, telling the doctor to hurry up. Dr. M. had all his dislikes bottled up in his breast ready to explode and unfortunately for the poor fellow, he had on an old blue Federal cavalry round-about with a corporal's stripes on the arm. This was like waving a red flag at a mad bull, and my old friend let loose.

"Were you in the Yankee army?"

"Orr dothter for Goth's sake fix my j j jaw," he tried to say with his mouth full of "slobber" and his eyes streaming.

"Well, get that dam jacket off or I might forget myself and kill you before I get your jaw back," said the old guerilla doctor. They took him seriously and almost stripped him.

"How about my fee?" asked Dr. M.

"Orr thas all right doc, get my j j jaw in, ef you plheashe."

"'Taint all right, I want it in advance," said the doctor.

"Buth you aint goth my j j jaw bath."

"It ain't going back until you put fifteen dollars in my hand."

"It ith too muth," the victim tried to say.

"Come on, Bryce I had rather leave him to suffer and catch flies than to have his money," he said, and catching up his bag he started towards the gate.

"Hold on dothter, hold on dothter here's the moneth," he said. Dr. M. pocketed the cash, pulled off his heavy old army leather gloves, jammed his thumbs back on his lower molars and pressed down until he nearly split those jaws, when the wandering jawbone slipped back with a cluck, audible and forcible, to the great relief of the unhappy sutler.

On our way home, I asked the doctor why he overcharged the poor fellow five dollars. "I put that extra five on to match that beautiful uniform," he said with a wicked grin.

C. A. Bryce, M. D.
516 N. 10th St., Richmond, Va.

## "MANAGEMENT OF ABORTIONS"

Referring to the article on "Management of Abortions", by Dr. Amos T. Fisher, Clinical Medicine for July, p. 480, a few remarks may be of great help to many physicians.

I do not wish to enter into a full discussion on the surgical treatment of abortion, but simply state what method as routine treatment has proven to be unfailing in every case that came under my care so far, during twenty-five years of general practice. Some of the patients apparently were moribund.

In this condition, after sepsis has set in, the physician should never attempt to waste time to have the patient brought to a hospital, because that usually means death to the patient. Five or ten minutes' delay may mean death.

In such cases, to take time for special cleaning may be dangerous delay. Proceed at once to empty the uterus if it contains fetid matter, but never by curettage; that opens the way into the circulation. Simply use a pair of forceps and draw the secundines out, even in fragments, if it is not possible to take them as a whole. Then swab the uterus with 95-percent carbolic acid, saturating a cotton swab wrapped firmly on applicator or dressing forceps; hold in the uterus one-half minute; then swab in the same manner with cotton wrapped on an applicator saturated with alcohol. Allow this to remain in the uterus a little longer. Then pack the uterus lightly with 5-percent iodized gauze. Follow this with an ichthyol, 10 percent in glycerine tampon and give the patient full doses (to saturation) of calcium sulphide tablets (pills).

For the fever, administer a medium dose of Epsom salts, per rectum, four to six drachms of Epsom salts in a pint of warm water. If there is danger of peritonitis, this dose should

be repeated and allowed to remain in the bowel. If there is any way you can save a patient's life after sepsis has set in, this treatment will do that.

In ordinary cases of abortion, empty the uterus aseptically and let nature do the rest; but, if a chill follows or the temperature becomes abnormal, due to absorption from fetid matter, then lose no time and resort to the same treatment as directed for sepsis. This, carefully carried out, will prevent loss of life in all cases not otherwise complicated.

R. WILLMAN.

St. Joseph, Mo.

## "CHRISTIAN SCIENCE" ENTERS A PROTEST

As your journal is "devoted to accuracy, dependability and honesty in every department"—to quote from your monthly announcement—kindly allow me to inform you and to inform your readers that a misstatement with reference to Christian Science appeared in the "Let's Talk It Over" department of your July issue under the heading "Suggestion—or Mental Therapeutics." The contributor of this article, while discussing healing of disease by psychology said of Christian Science and faith cures, "They are made by suggestion and suggestion only." Now, this statement conveys a very wrong impression of Christian Science practice. Christian Science is not suggestion, mesmerism, nor a product of human will. It is not the influence of one human mind over another. Christian Science is a religion based upon and in accord with the teachings and practice of Christ Jesus. The physical healing of Christian Science results from the operation of divine law in human consciousness. It is a ministry of salvation which fulfills the promises of the Founder of Christianity.

HUGH STEWART CAMPBELL.

Chicago, Ill.

## NOTES AND REFLECTIONS ON AN OLD ISSUE OF "CLINICAL MEDICINE"

A few notes on your July 1923 issue. Why not? Because it is a habit of mine to skim over the new journals, and to read thoroughly the back numbers when I have time and am in a receptive mood. Unless, indeed, there is some article which applies to a present need.

I think this July number has an unusually large number of good contributions. Doctor Blech, for instance, on "Acute Pancreatitis", is very helpful, because he gives insight into conditions which are often obscure. The "Seminar" is well worth its space.

Always, Doctor Rittenhouse was interesting and profitable. I deeply regret his passing.

The editorial on "Vicarious Menstruation" is good. I have had several undoubted cases where the new channel was compensatory—a way nature has of getting even with her enemies.

Dr. W. B. Snow's rather technical article on "The Therapeutics of Radiant Light and Heat", is neutralized by the next paper on "Radiant Light and Heat in Orthopedic Conditions", by Doctor Frauenthal.

Doctor Bulkley's splendid suggestive 250 cases of "Cancer of the Breast" follows.

You are very generous to give Doctor Morris so much room for his "Standardization", a characteristically southern, breezy, expansive, non-consequential bit of talk. Its *genre* reminds me of the talk of a delightful old Kentucky colonel who said he never thought of what he was going to say until he had said it. And then he always wished he had said about seventy-five percent less than he did.

I am sorry to say that I think "The Law and the Profits" a poor attempt at a story. Wouldn't Doctor Thackeray's "Materia Medica" papers look and read better in book form rather than in a monthly journal? Periodicals are apt to be mislaid, and such articles need to be kept for convenient reference.

Doctor Bryce's talk is always interesting. I quite agree with his "Over Treatment in Arthritis", after an experience of some thirty years.

Beverley Robinson (who also has gone from us since his paper was written) is practical and scientific, but what shall we say of Doctor Page of Boston? Does he INSIST on our walking on all fours? If not, what—in view of his article—are we going to do about it? "It is for us a method counteracting the dropping down of the inwards by frequently assuming the attitude of the monkey and the kangaroo, instead of remaining forever upright." If we are to resume the primitive attitude, I am afraid that our styles of dress will have to be radically modified. And to this, what would our women say?

And Doctor Deachman, from the scientific center of Chicago, advocating Hippocrates, and "urine as a therapeutic agent"! I should not wonder if he hailed from the Eddyite city, or even from Los Angeles—but Chicago!

My old friend Dr. G. W. McCoy, of Washington, tells of the outgrowth of vaccination, robbing Jenner somewhat of the sole honor of discovery. Surely, there is "nothing new under the sun".

I think the "Credit Bureau" idea (p. 528) a very good one. It should be taken up by our medical societies.

Doctors do not like to "blacklist" those unable to pay, or dilatory debtors who find it hard to pay promptly, but only those who will not pay when they can, or claim they have not received full value, or who make other excuses to evade just and reasonable obligations.

Such persons should certainly be given publicity and suffer the consequences of their dishonesty.

E. S. GOODHUE.

Roosevelt, Molokai.

[It is always a pleasure to read anything Doctor Goodhue may write. He is invited to come again.—ED.]

## THE INTER-STATE POST GRADUATE ASSEMBLY

The Inter-State Post Graduate Assembly, directed by the Tri-State District Medical Association, extends a hearty invitation to the physicians of America who are in good standing in their State or Provincial Societies to attend the annual assembly, which is to be held at Milwaukee, Wisconsin, October 27th, 28th, 29th, 30th and 31st, five full days of post-graduate work.

Among the eminent members of the profession and citizens who have accepted places on the program are the following:

Dr. Nicholas Murray Butler, President of Columbia University, New York, N. Y.

Sir Arthur William Currie, President of McGill University, Faculty of Medicine, Montreal, Canada.

Merritte W. Ireland, Surgeon-General of United States Army, Washington, D. C.

Monsieur J. Jusserand, French Ambassador to United States, Washington, D. C.

Edward E. Stitt, Surgeon-General of United States Navy, Washington, D. C.

Professor Theodore Tuffier, Professor of Surgery, Faculty of Medicine, Paris, France.

Dr. John V. Barrow, Los Angeles, Cal.

Dr. W. F. Braasch, Mayo Clinic, Rochester, Minn.

Dr. George E. Brewer, Emeritus Professor of Surgery, Columbia University, College of Physicians and Surgeons, New York, N. Y.

Dr. Alan Brown, Professor of Pediatrics, University of Toronto, Faculty of Medicine, Toronto, Canada.

Dr. Ralph C. Brown Assistant Professor of Medicine, Rush Medical College, Chicago, Ill.

Dr. C. Macfie Campbell, Professor of Psychiatry, Harvard University, School of Medicine, Cambridge, Mass.

Dr. Walter T. Connell, Professor of Medicine, Queen's University, Faculty of Medicine, Kingston, Canada.

Dr. John F. Cowan, Professor of Surgery, Stanford University, School of Medicine, San Francisco, Cal.

Dr. George W. Crile, Professor of Surgery, Western Reserve University, School of Medicine, Cleveland, Ohio.

Dr. Samuel J. Crowe, Clinical Professor of Laryngology, Johns Hopkins University, School of Medicine, Baltimore, Md.

Dr. LeRoy Crummer, Professor of Medicine, University of Nebraska, College of Medicine, Omaha, Neb.

Dr. Walter E. Dandy, Associate Professor of Surgery, Johns Hopkins University, School of Medicine, Baltimore, Md.

Dr. William Darrach, Dean and Associate Professor of Surgery, Columbia University, College of Physicians and Surgeons, New York, N. Y.

Dr. Vernon C. David, Assistant Professor of Surgery, Rush Medical College, Chicago, Ill.

Dr. David J. Davis, Professor of Pathology and Bacteriology, University of Illinois, School of Medicine, Chicago, Ill.

Dr. John B. Deaver, Professor of Surgery, University of Pennsylvania, School of Medicine, Philadelphia, Pa.

Dr. Laurence R. DeBuys, Professor of Pediatrics, Tulane University, School of Medicine, New Orleans, La.

Dr. George F. Dick, Assistant Professor of Medicine, Rush Medical College, Chicago, Ill.

Dr. Charles A. Elliott, Professor of Medicine, Northwestern University, School of Medicine, Chicago, Ill.

Dr. Leonard W. Ely, Professor of Surgery, Stanford University, School of Medicine, San Francisco, Cal.

Dr. Joseph Evans, Professor of Medicine, University of Wisconsin, School of Medicine, Madison, Wis.

Dr. A. MacKenzie Forbes, Clinical Professor of Orthopedics, McGill University, Faculty of Medicine, Montreal, Canada.

Dr. William Goldie, Associate Professor of Medicine, University of Toronto, Faculty of Medicine, Toronto, Canada.

Dr. Marvin L. Graves, Professor of Medicine, University of Texas, School of Medicine, Galveston, Texas.

Sir Henry Gray, Royal Victoria Hospital, Montreal, Canada.

Dr. Don M. Griswold, Professor and Head of Department of Preventive Medicine and Hygiene, State University of Iowa, Iowa City, Iowa.

Dr. Garfield M. Hackler, Professor of Surgery, Baylor University, School of Medicine, Dallas, Texas.

Dr. John A. Hartwell Associate Professor of Surgery and Clinical Surgery, Cornell University, Medical College, New York, N. Y.

Dr. Carl A. Hedbloom, Professor of Surgery, University of Wisconsin, School of Medicine, Madison, Wis.

Dr. William B. Hendry, Professor of Obstetrics and Gynecology, University of Toronto, Faculty of Medicine, Toronto, Canada.

Dr. Russell D. Herrold, McCormick Institute for Infectious Diseases, Chicago, Ill.

Dr. Julius H. Hess, Professor of Pediatrics, University of Illinois, School of Medicine, Chicago, Ill.

Dr. Russell A. Hibbs, Professor of Orthopedic Surgery, Columbia University, College of Physicians and Surgeons, New York, N. Y.

Dr. Frederick J. Kalteyer, Associate Professor of Medicine, Jefferson Medical College, Philadelphia, Pa.

Dr. Allen B. Kanavel, Professor of Surgery, Northwestern University, School of Medicine, Chicago, Ill.

Dr. Ralph A. Kinsella Associate Professor of Medicine, University of St. Louis, School of Medicine, St. Louis, Mo.

Dr. Francis H. Lahey, Professor of Clinical Surgery, Harvard University, School of Medicine, Boston, Mass.

Dr. Dean Lewis, Professor of Surgery, Rush Medical College, Chicago, Ill.

Dr. LeRoy Long, Dean and Professor of Surgery, University of Oklahoma, School of Medicine, Oklahoma City, Okla.

Dr. William E. Lower, Professor of Urology, Western Reserve University, School of Medicine, Cleveland, Ohio.

Dr. Charles B. Lyman, Professor of Clinical Surgery, University of Colorado, School of Medicine, Denver, Colo.

Dr. N. J. MacLean, Associate Professor of Surgery, University of Manitoba, Faculty of Medicine, Winnipeg, Canada.

Dr. Ralph H. Major, Professor and Head of Department of Medicine, University of Kansas, School of Medicine, Rosedale, Kan.

Dr. Charles H. Mayo, Mayo Clinic, Rochester, Minn.

Dr. William J. Mayo, Mayo Clinic, Rochester, Minn.

Dr. Edward Miloslavich, Director of Department of Pathology and Bacteriology, Marquette University, School of Medicine, Milwaukee, Wis.

Dr. Roger S. Morris, Prof. of Medicine, University of Cincinnati, School of Medicine Cincinnati, Ohio.

Dr. Bernard H. Nichols, Department of Roentgenology, Cleveland Clinic, Cleveland, Ohio.

Dr. Walter L. Niles, Dean of Prof. of Clinical Medicine, Cornell University, School of Medicine, New York, N. Y.

Dr. William F. Petersen, Associate Prof. of Pathology and Bacteriology, University of Illinois, School of Medicine, Chicago, Ill.

Dr. Dallas B. Phemister, Assistant Prof. of Surgery, Rush Medical College, Chicago, Ill.

Dr. Harry M. Richter, Prof. of Surgery, Northwestern University School of Medicine, Chicago, Ill.

Dr. Stanley P. Reimann, Director of Laboratories, Lankenau Hospital, Philadelphia, Pa.

Dr. David Riesman, Prof. of Clinical Medicine, University of Pennsylvania, School of Medicine, Philadelphia, Pa.

Dr. Milton J. Rosenau, Prof. of Preventive Medicine and Hygiene, Harvard University, School of Medicine, Boston, Mass.

Dr. E. C. Rosenow Mayo Clinic, Rochester, Minn.

Dr. G. W. Stevens, Milwaukee, Wis.

Dr. Wallace Irving Terry, Prof. of Surgery, University of California, School of Medicine, San Francisco, Cal.

Dr. John H. J. Upham, Prof. and Head of Department of Medicine, University of Ohio, School of Medicine, Columbus, Ohio.

Dr. George Gray Ward, Jr., Prof. of Obstetrics and Gynecology, Cornell University, School of Medicine, New York, N. Y.

Dr. Louis M. Warfield, Prof. of Internal Medicine, University of Michigan, School of Medicine, Ann Arbor, Mich.

Dr. George Weaver, McCormick Institute for Infectious Diseases, Chicago, Ill.

Dr. Charles J. White, Prof. of Dermatology, Harvard University, School of Medicine, Boston, Mass.

Dr. Charles S. Williamson, Prof. of Medicine, University of Illinois, School of Medicine, Chicago, Ill.

Dr. Milton C. Winternitz Dean of Yale University, School of Medicine; Prof. of Pathology and Bacteriology, New Haven, Conn.

Dr. John A. Witherspoon, Prof. of Medicine, Vanderbilt University, Medical Department, Nashville, Tenn.

Dr. John L. Yates Milwaukee, Wis.

Dr. Hugh H. Young, Clinical Prof. of Urology, Johns Hopkins University, Medical Department, Baltimore, Md.

Dr. Abraham Zingher, Assistant Prof. of Hygiene, University and Bellevue Hospital, Medical College, New York, N. Y.

The Tri-State District Medical Association is supervising an Inter-State Post Graduate Clinic Tour to Canada, British Isles and France, to start May 18, 1925. Leading teachers and clinicians of Canada and Europe will arrange and conduct clinics and demonstrations in the following clinic cities:

Toronto and Montreal, Canada; London, Liverpool, Leeds, Manchester and Newcastle, England; Edinburgh and Glasgow, Scotland; Dublin and Belfast, Ireland; Paris, Lyons and Strasburg, France.

Besides the main tour, special tours to prac-

tically all the leading centers of Europe will be arranged. Sight-seeing trips to all places of interest in the countries visited will be included in the regular tour.

Cost of tour, including first-class hotels, board, steamship, clinic arrangements and all ordinary traveling expenses, under $1,000.00.

The tour is open to physicians in good standing in their State Societies, their families and friends who are not physicians.

For information, write the Managing-Director, William B. Peck, Freeport, Ill.

## EPONYMS OF DERMATOLOGY

The field of medicine, especially the specialty of dermatology, seems very rich in having diseases called after those who first observed or named them. The use of such eponyms has become engrained in our speech and literature. When understood, the substitution of the name of a person for that of the disease need not be condemned; but, all too often, more than one disease has been named after one clinician, and more than one disease is known by many personal names. I recently prepared a long paper on some of the eponyms of dermatologic diseases which was published in the *Archives of Dermatology* for June 1924. The two stories that follow are of the practical founders of English-speaking dermatology.

*WILLAN'S LEPROSY. Psoriasis.*—Robert Willan was born in 1757, and died in 1812. He was an English Quaker. He has been variously called the creator of dermatology, and perhaps, more truthfully, the initiator of a new era in dermatology, and founder of the modern epoch in skin diseases. The history of dermatology may well begin at this period of Willan. He gave the first valuable classification of skin diseases, and was the first to attempt a complete classification. Willan followed Plenck's system. Plenck, Doctrina de morbis cutaneis (1783; German, 1789) divided diseases of the skin according to the form of their pathological products. Willan's system may be found, "On Cutaneous Diseases", 1808, and "Arrangement of the Diseases of the Skin", in Cullen, "Synopsis of Nosology", (London, 1828, pp. 141-151).

Willan was famous for his judicious selection and accurate definition of terms. He extricated psoriasis from the heterogeneous group of skin diseases. He divided the purpuras into simplex and hemorrhagic. He cleared up the nature of eczema for his time, and distinguished lupus from other dermatoses, hence, Willan's lupus. He distinguished tinea versicolor from the other pigmentary diseases. He gave the original descriptions of prurigo (mitis), ichthyosis, and pityriasis (Practical Treatise on Porrigo or Scalled Head and on Impetigo, etc., edited by Smith, 1814). Willan did not complete his work "On Cutaneous Diseases" (1796-1808, vols. 1 to 4) (later translated into German), but his student and successor was responsible for "Practical Synopsis of Cutaneous Diseases According to the Arrangement of Dr. Willan" (London, 1815.) Willan and Bateman were accredited jointly for the description of herpes iris (Bateman's disease), Delineation of Cutaneous Diseases, 1817. These co-workers were accredited with describing five varieties of impetigo: figurata, sparsa, scabida, erysipeaiatoides, and rodens. The first four, according to Crocker, were probably eczematous, or impetigo contagiosa, the last probably tertiary syphilis or rodent ulcer. Under the name of ichthyosis cornea, Willan quotes the first known case of scleroderma, that of Curcia of Naples, 1752.

*BATEMAN'S DISEASE. Molluscum contagiosum.*—Thomas Bateman was born in Whitby, England, on April 29, 1778. He was a student of Robert Willan, who has been accredited with having been the father of modern English dermatology. Bateman studied in London and Edinburgh. His thesis was on the subject of petechial hemorrhages. Molluscum contagiosum is not the only disease accredited to Bateman, as will be seen by consulting the list which follows:

*BATEMAN'S DISEASE. Purpura senilis.*—Bateman distinguished this type of hemorrhagic spots (Bateman's Atlas, 1828, Plate xxx; as well as "De haemorrhoea petechiale," 1801) which occur incessantly for years without general disturbance, in aged individuals, predominantly on the forearms. These are related to senile degeneration of the skin.

*BATEMAN'S DISEASE. Alopecia areata.*—Occasionally one finds this eponym in the literature.

*BATEMAN'S ECTHYMA.*—Bateman is accredited with the first description of this disease.

*BATEMAN'S DISEASE. Lichen urticatus.*—This disease was also first described by Bateman.

*BATEMAN'S DISEASE. BATEMAN'S HERPES. Herpes iris.*—This manifestation is accredited to Bateman. The type is rare, as around a central bulla one finds a ring of vesicles. (See Bateman's Atlas, Plate lii.)

Batement knew cheilitis exfoliativa as "psoriasis labialis".

Bateman was a worthy successor to Willan,

and not only completed but amplified the teachings of the senior in "Delineations of Cutaneous Disease" by Willan and Bateman (London, 1817, 1840 and 1849). There was an earlier work by Bateman, "A Practical Synopsis of Cutaneous Disease According to the Arrangement of Dr. Willan", 1813. This ran into several English editions as well as a French translation and three German ones; a Swedish translation appeared and an American edition.

Bateman died on April 9, 1821. (See "Some Account of the Life and Character of the late Thomas Bateman," London, 1826.)

HERMAN GOODMAN.

New York City.

## BISMUTH IN TUBERCULOSIS. PNEUMONIA IN CHILDREN

I have found a new use for bismuth in the treatment of tuberculosis. My treatment is to give one or two calcreose tablets every four hours with a large drink of cold water, for three days, then stop; and give soluble iodine, one drop in half a glass of water, three a day, one hour before meals, gradually increasing to five drops; give for three days and stop. Then give an intramuscular injection of bismuth. Continue treatment for two months.

Here are two prescriptions for the treatment of pneumonia in infants and children. These prescriptions are as near a specific in medicine as you can get in the treatment of children and infants. In infants, I give the following:

Bicarbonate of soda.....gr. ½
Calcidin.....gr. ⅛
Quinine sulphate.....gr. 1/10

One tablet every three hours for three doses; then one tablet every six hours.

In cases of pneumonia occurring in children three to six years old, I prescribe:

Bicarbonate of soda.....gr. 1
Calcidin.....gr. ⅛
Quinine sulphate.....gr. 1/6

One tablet every three hours for four doses; then one tablet every six hours.

G. M. FISHER, JR.

Amaranth, Pa.

[The use of bismuth as a remedy for tuberculosis is new to us. Have other readers of CLINICAL MEDICINE tried the drug for this purpose, and, if so, with what results? Bismuth, given intramuscularly, is now established as a valuable remedy for the treatment of syphilis. In fact, many physicians look upon it as being more efficient, as well as safer, than mercury. The arsphenamines still hold first place.

Calcidin is, of course, a remedy of recognized merit in acute respiratory disease. The combination with quinine seems to us rational.

We are glad to get these therapeutic notes, and hope other physicians will do likewise. —ED.]

## A SPONTANEOUS CURE OF EXOPHTHALMIC GOITER

Doctor Waugh in his "Alkaloidal Practice" states that: "Exophthalmic goiter is characterized by tachycardia, thyroid enlargement and exophthalmos with tremors."

"Some attribute it to disease of the central nervous system, others to disease of the sympathetic nerves, while still others look to the thyroid body itself for the origin of the disease." Whatever may be the cause, the disease is manifested by excessive action of the thyroid body with consequent overstimulation of the heart and engorgement of the vessels of the orbit.

The disease is much more common among women than men in rather ungainly proportions, and it finds its victims at all ages.

Doctor Waugh further states: "Periods of arrest occur, and these may be permanent."

This last statement is undoubtedly a fact, and, yet, the case that I am reporting is the first that I have met within over fifty years of practice.

Mr. Russel K., twenty-eight years of age, five feet eleven inches tall, of slender build and only fairly nourished; first noticed the invasion of the disease early in 1918, the first symptom being polyuria, the flow being about two gallons at night with a total of three gallons per day. This was followed by severe nervous attacks and rapid heart action with some dyspnea. The patient, early in 1919, first noticed protrusion of the eyeballs, the left eye being the largest.

My acquaintance with the patient commenced in the latter part of 1919, he being, at that time, a clerk in one of our grocery stores. My attention was attracted to him by the choreatic movements which seemed to affect every muscle in his body. This caused me to look at his eyes and I found a great protrusion of the eyeballs with a constant stare, the upper lid being retracted.

I now began to ask questions and he gave me the information as to the commencement of the trouble.

I made a rather superficial examination. The pulse was very rapid and irregular; the thyroid did not appear to be enlarged; and the constant nervous action was like chorea, twitching and jerky. He was almost constantly moving and seemed unable to either stand or sit in one position for a fraction of time.

Mr. K. had been treated by local physicians but received no benefit and, in 1921, he went to San Antonio and consulted a doctor there who prescribed thyroid extract, and this treatment was continued until January, 1922, when, as he could notice no improvement, he abandoned the use of all medicine, concluding that there was no help for him.

Then nature took hold of the case and the first improvement noticed was a diminution in the amount of urine passed; then the heart symptoms became less noticeable; the eyeballs commenced to recede, and, finally, the nervous excitement left him and he realized that he was getting better and his mind became impressed with the idea that he was getting well. At this date, August, 1924, he is better than at any time during his life; so he says.

My examination at this writing shows: pulse 70, fairly full and easily compressible; hearts sounds normal; choreatic movements entirely absent; thyroid gland normal in size; left eyeball shows a dilated blood vessel on the conjunctiva on the nasal side; winking of the eyelids resumed.

The patient smokes cigarettes moderately, but I have advised him to discontinue the practice. I also advised him that his use of coffee should not exceed one or two cups, of mild decoction, during the day.

The case, while presenting nothing extraordinary, except the pronounced choreatic movements, has interested me for some time and the outcome has been a surprise.

I offer it as being unique and of interest because of what might happen in the practice of others.

W. T. THACKERAY.

Fowlerton, Texas.

## INTRAVENOUS THERAPY—WHAT DO YOU KNOW ABOUT IT?

On every hand we hear that there is a great increase of interest in the intravenous use of medicines. A tremendous impetus has been given to this method by the success obtained in treating syphilis with the arsphenamines, which are generally introduced by the intravenous route.

We want to hear from the readers of CLINICAL MEDICINE on this topic, and I therefore urge everyone of you who has ever used intravenous medication to write me fully concerning your experiences. This doesn't mean that we expect you to indorse intravenous therapy necessarily; we want you to tell the truth about it, as you see it. Here are some questions which you may feel like answering:

1.—How long have you been using intravenous medication and how did you come to take up this method?

2.—What drugs do you use by the intravenous route?

3.—What diseases or conditions are you treating by the intravenous route?

4.—Do you find the intravenous method of treatment of value in both acute and chronic diseases? If so, in what conditions?

5.—Report specifically about the results obtained and methods employed in treating such conditions as high blood pressure, rheumatism, anemia, malaria, tuberculosis.

6.—Have you used the method of treating septicemia advocated by Doctor Young, of Johns Hopkins, with gentian violet and mercurochrome 220? What results?

7.—Have you used acriflavine, metaphen, or other powerful antispetics intravenously in septicemia, and if so with what results?

8.—Describe fully a few specific cases in which intravenous medication was used by you.

Various ideas and suggestions on this topic will undoubtedly arise in your mind. Let us have them. We want an open, free, spontaneous discussion of this interesting method of treatment.

A. S. BURDICK.

Chicago, Ill.

## ADAPTING NUTRITION WORK TO A COMMUNITY

The New York Association for Improving the Condition of the Poor has issued a report prepared by Miss Lucy H. Gillett, Superintendent of its Nutrition Bureau, describing the methods employed and summarizing the results of an intensive campaign against malnutrition which the A. I. C. P. has been carrying on in the Mulberry district of New York City. The report states that, of 2,181 apparently well children examined in the medical clinics at Mulberry Health Center, 656, or 30 percent, were diagnosed as malnourished. Since much of the sickness and lowered vitality in later life is the result of poor nutrition, as physicians have frequently stated, the importance of providing educational guidance in

nutrition as well as providing attention for the correction of physical defects is of tremendous importance.

If these children were in danger from fire or industrial accidents, the report states, every safety device and preventive measure known would be urged to protect them. Although the results from malnutrition are much slower, often much more indirect and much less dramatic than those from fire or accidents, they are even more deplorable because of the larger number affected and the misery resulting.

Many a wage earner is unable to increase his income to the safety level because of health conditions due to poor nutrition. Too many children who apparently show no signs of disease or malnutrition are allowed to drift into the wage-earning period with only a part of their rightful earning capacity developed. Thus handicapped, there is danger that they may add to the responsibility of the health and social agencies.

Miss Gillett's report states that, before any method for combating malnutrition can be decided upon, it is necessary to deter mine (1) what nutrition work is being done and what other nutrition work should be done in the district; (2) what is the prevailing nationality, and what is their social and educational background; (3) are preventive or curative aspects of nutrition to be emphasized, or both; (4) shall the work be conducted in the interest of the pre-school child, the school child, the adult, or for everyone in the community; and (5) what method shall be used?

The problem may be approached through small groups, through intensive work in individual families, or through general educational work with large groups, or a combination of any two or all three. The small group may be used with school children or intelligent mothers or pre-school children. It is useful in either a curative or preventive program. There are arguments for and against nutrition work exclusively in groups.

The following arguments for the group method are advanced: (1) one small group frequently arouses the interest of a whole neighborhood by providing a graphic illustration; (2 )a large number may be reached in a short time; (3) the class spirit often gives a child courage to venture on new habits; (4) because cooperation is frequently secured more quickly, the class sometimes reduces the number of home visits required.

Arguments against the group method are: (1) home conditions cannot be as completely corrected—the work is not as thorough; (2) the class spirit which prompts some good habit formation is removed when the class is over and children are apt to return to old habits; (3) too many children are living under conditions which they are powerless to correct and about which the parents are indifferent; (4) in such cases, home visits are necessary. Home visits in addition to the class period and preparation for it often take more time than home visits alone; (5) the pre-school child himself can be taught comparatively little in groups. Intensive work in the home could often be done in the time it takes to get mothers to come to class; (6) each worker has to decide for herself whether her conditions are favorable for group work; (7) intensive work is always a necessary part of the curative program in cases where individual problems exist or where the cooperation of the parents is difficult to obtain; (8) general educational work may be used most effectively as a preventive measure, though doubtless much malnutrition may be cured thereby too.

During the four and one-half years of intensive work covered in the A. I. C. P.'s report, intensive care was given to 1,018 malnutrition cases and in addition the habits of all the boys and girls in the families of these special malnutrition cases were influenced. With an average of 3.8 children per family, 2,578 children received attention. There is much evidence that the work spreads to other families in the neighborhood. We frequently hear of mothers who give milk and cereals to their children because children under our care were advised to use these foods.

Group work would naturally seem more economical of time than intensive home visits, but it was extremely difficult to get these women (who were mostly Italians) out at stated intervals and much time was lost thereby. The average cost per visit in a home has been estimated to be 37 cents. The average cost per person per lesson where the women were taught in groups was estimated to be 36 cents, with an average attendance of 8 per lesson. With practically the same cost per individual and with more satisfactory results from intensive work, in this particular neighborhood the malnourished pre-school child was handled more economically through intensive work than in groups. School children can doubtless be handled more economically in large numbers.

The report describes the methods employed and the results obtained through nutrition classes, little mothers' clubs, poster clubs, mothers' groups, and nutrition classes in the schools.

# Let Us Play

Conducted by All of Us

## The Auto Tourist and Country Inns

MY wife and I have just returned from an automobile trip through New England and other eastern states. So many have described in detail the scenic beauties of this section that at this time I will not undertake to go into this feature. Before leaving I had the pleasure of reading Doctor Drueck's interesting story of his motor trip through the Connecticut River Valley and New Hampshire. I can endorse what he said about the beauties of New Hampshire, for our pilgrimage included a visit to the White Mountains. Sometime I may write something about the places we visited. In this short article I shall undertake to give only our impressions concerning country inns, for throughout our trip we kept away as much as possible from large cities, and spent every night except one in some country village.

By the way of introduction, I may say that in the eastern states there doesn't seem to be as much camping by the wayside as in the middle and far west; nor have the towns and villages, as a rule, provided free camp sites. Nevertheless, there are many automobile tourists in this section who camp out, either because they like it or because they find it cheaper to do so. I will confess that neither my wife nor I have been able to get up any great enthusiasm about sleeping outdoors. Some years ago I bought a tent, cots, cooking utensils, and the other paraphernalia for camping, had a big box made to carry on the running board of my car, and started for Minnesota. We slept out two nights. The first night we got along fairly well, in spite of innummerable mosquitoes, which we were unable to keep entirely out of our tent. The second night, when we were camping on the banks of the Mississippi River, one hundred miles, or more north of the Twin Cities, we were caught in a very severe rain and hail storm. That cured us. We have never camped out since.

I believe there are many automobile tourists among the readers of CLINICAL MEDICINE who, like the good wife and myself, prefer to sleep in a bed at night, and who, after a hot day's drive, perhaps over dusty roads, during which they have collected all the dirt, dust and grease of automobile traveling, welcome a good bath and a good meal in a pleasant, well-shaded country inn.

I think it was Hilaire Belloc who, in his observations on America, after a short visit to this country, made this criticism—he found everything too much standardized, too uniform. Indeed, the principle of "fabricated construction" applied even to the hotels. All of the hotels in the large cities which he visited were exactly alike as regards furnishings, service, meals, etc. In America every concern (even the hotels) which is not strictly up-to-date, meaning exactly like its fellows, is out of the running. "Antiquity" means that it is behind the times. In Europe, on the contrary, antiquity is a thing to be desired, and the differences between the various inns and hotels are perpetuated and give to each of them a certain flavor of distinction.

This criticism of Mr. Belloc seemed to me quite to the point. As a matter of fact, there is one large hotel supply firm which probably supplies the furnishings and equipment for ninety percent of the hotels in this country. I have always suspected that there must be a school for hotel chefs in which they have all learned to cook, because in all of them the dishes seem to be exactly alike.

And what has all this to do with country inns? This: In our trip we found that, at least as regards the country inns, there is an immense difference between the different places, and a certain "flavor", if you please, which is very attractive to one who has spent much time in city hotels. Throughout New York, Pennsylvania and New England—and I presume in many other parts of the country as well—there are many really excellent country inns in which it is a delight to stop. Also,

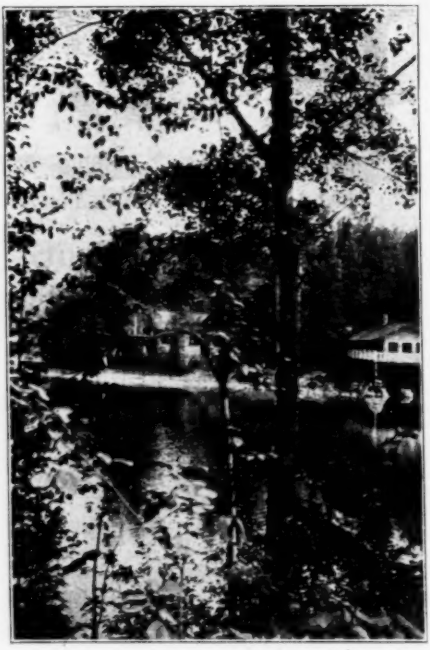
there are many poor ones. For obvious reasons I shall not attempt to tell you about the poor ones in this article, though some of them I would like to describe so you may beware of them if you go over the same ground that we went over. The purpose of this article is to tell you about some of the good places where we stopped.

We had a Blue Book with us, and to quite an extent we were guided in our selection of hotels by the advertisements in this book. In this way we found a number of excellent places, but we also found that the advertisements were not to be relied upon; for instance, the advertisement of one hotel in New Hampshire proclaimed to the world that the cooking was "the best in New England". We found it positively the worst! Also, our room, on the third floor, gave us a beautiful view of a tin roof; we couldn't see over it.

And now for some of the specific places, beginning in the state of New York. We had dinner only at the Chick Inn, Kennedy, N. Y., which is a few miles east of Jamestown. We did not stay over night there, although I understand they keep a few lodgers. This is a farmhouse which has been rebuilt into a wayside inn. It is unpretentious, but is quiet, clean, and the meals are of the very best. The young people who run it, Mr. and Mrs. Whitney, are educated country people. Mr. Whitney is a college man; his wife is a graduate of a Chicago college of music. We enjoyed our meal, and we enjoyed fully as much getting acquainted with this pleasant couple.

Chick Inn, Kennedy, N. Y. Some place for chicken.

Quite a different place is the Jefferson Hotel, at Watkins. Here we stayed all night. This is a modern hotel, on a business street, but in a building nearly a century old, which has been reconstructed so as to make it thoroughly comfortable. The prices are fairly



Paradox Lake, in the Adirondacks.

moderate—much less than at the big hotel on the hill. I recommend this place to anyone wishing to visit Watkins Glen, though it is distinctly not a "country inn", as I have used the term.

One of the pleasantest country inns visited on our trip was the Sherburne Inn, at Sherburne, N. Y.; also, the prices were extremely moderate. In fact, I feel we really got more for our money at this place than anywhere else we stopped. This is run by Mr. and Mrs. Colton. As it was vacation time, their two daughters, college girls, were at home. These nice people gave it a pleasant, homelike flavor, and seemed to take personal pleasure in making us comfortable. The hotel was built, as I understand it, by money contributed by some of the well-to-do people of Sherburne, who, having a beautiful village, desired a good place of entertainment for themselves as well as for the visitors in their midst. At Sherburne they have a good public library, endowed by one of their own people. One of the young ladies introduced us to the librarian, who lent us books to read at the hotel. My wife met on the streets two nice old ladies, who invited us to their home. Altogether we carried away a very pleasant impression of this

At Schroon Lake. Mr. and Mrs. Shattuck and Mrs. Burdick.

village, which probably has a population of only 1500 or 2000. Incidentally, it is only twelve miles from Norwich, the home of the Norwich Pharmacal Co., where I visited friends.

We drove into the Adirondacks and stopped all night at Schroon Lake. The inn at which we stopped was comfortable, but not distinctive. There is located in this place, however, a very pleasant place, known as the Brown Swan Club. This we were told was exceedingly comfortable, restricted as regards the character of its patronage, but the prices rather high.

We did not stop at any inn in the state of Vermont, in which state we spent but one day; we were entertained by friends at their summer cottage on the shore of Lake Champlain, at a delightful spot near Burlington; therefore, I can tell you nothing about the Vermont hotels.

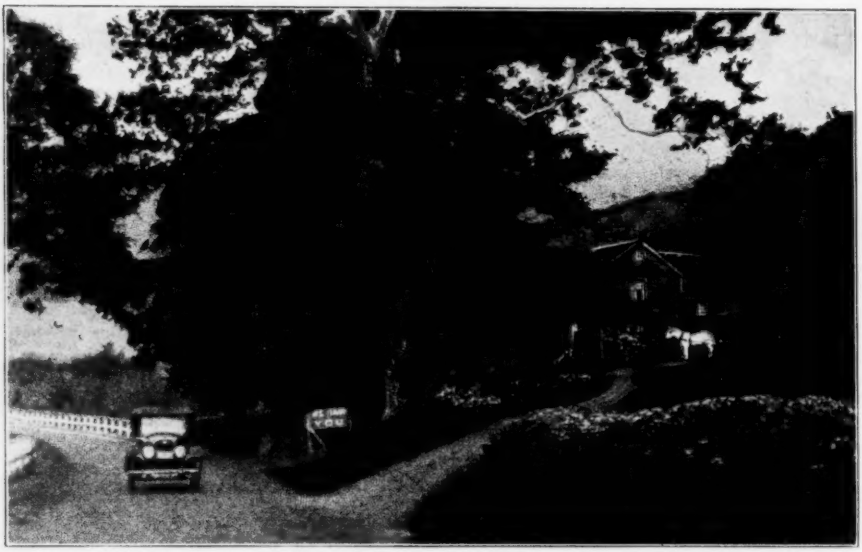
Williamstown, Mass., the seat of Williams College, is one of the most beautiful villages in New England. This is a village in which one could profitably spend a month, especially during the annual conference on world affairs which is held there by the college every summer. The Greylock Hotel, named after the mountain which towers over Williamstown and rises above the surrounding hills, is an unusually nice place. It is conducted along modern hotel lines, and the prices are about the same as those of the average city hotel. The hotel has, however, a pleasant academic flavor. There is an oldfashioned air about it which we enjoyed.

From Williamstown we drove over the wonderful Mohawk Trail, in a pouring rainstorm, which made it hard to appreciate the scenery because all my attention was concentrated on the car, which, to a western man, seemed in perpetual danger of sliding off from the well-oiled highway. Just at the foot of the mountains, on the eastern side, is the little village of Charlemont. As Mrs. Burdick's great-great-grandfather lived in this vicinity, we wanted to stop here for a day. We put up at the Charlemont Inn, which lies directly on the mountain trail. This has been in operation for at least forty years, and the surroundings are delightful. We awoke in the morning to the music of a mountain brook, tinkling along over the stones under our bedroom window. The inn has a collection of old engravings, drawings, maps and photographs made by the late Chief Justice Aiken, all illustrative of the history and development of this section of western Massachusetts. We spent some pleasant hours looking these over. The former owner of the inn, Mr. Sears, called on us in the evening to tell my wife something about Charlemont and the neighboring town of Heath, where my wife's ancestor is buried. The rooms were very comfortable and there was excellent home country cooking.

The Colonial Inn in Concord is an oldfashioned house, in an oldfashioned town, where much history has been made. Nearby is the Concord Bridge where

> ". . . once the embattl'd farmers stood
> And fired the shot heard round the world."

In this village are the homes of Thoreau, Emerson, Hawthorne and the Alcotts. At one time Concord was almost the literary capital of the United States. The inn naturally partakes of the atmosphere of its surroundings. However, I came very near not sleeping there at all. My wife decided to spend the day in the inn, while I visited my friend Ralph Patch, of the E. L. Patch Co., at Rockport, where we had a picnic, and at Gloucester, where I was shown his method of making cod-liver oil. The consequence was that I did not get back to Concord until about midnight.



Old Buttonball tree and boyhood home of Charles Dudley Warner, Charlemont, Mass. Mohawk Trail.

All the garages were closed and locked, and likewise the hotel. I fear that the car and I would have slept on the street if my wife had not been sitting up with the latch key to let me in. I am sure that my reputation has suffered at the hands of the good people of the Inn, who must look upon me as a dangerous midnight reveler.

We found a number of delightful places at which we stopped for afternoon tea. One of the most interesting was Longfellow's Wayside Inn, South Sudbury, Mass. While a modern dining room and porch have been added, every effort has been made to preserve the spirit of the place.

The most pretentious place at which we stopped was the Muenchinger-King at Newport. We got into this place, however, by accident. The manager of another hotel could not take care of us, but telephoned over to the M-K and secured a room for us. This hotel does not look like a hotel at all. Apparently it is an old family mansion, connected by overhead galleries with another similar mansion on another street. There is no hotel office, and we were not asked to register. There is no hotel clerk, and we had difficulty in finding the man to whom we should pay the bill. It seems to be conducted much like the European hostelries of which Mr. Belloc is so fond, for it is certainly distinctive at every point. Our room was about 20x30 feet in size. Connected with this room were a large bathroom and a simply enormous closet. The furnishings were in the main old, but plainly expensive. The rugs were rich in coloring, and the furniture old-fashioned. The dining room does not look out upon the street, but upon an inner court, and on three sides this is banked by foliage plants. The services and the servants left nothing to be desired. We were not surprised to learn that certain of the Vanderbilt family were fellow guests. The price we paid for our accomodations at the Muenchinger-King was the highest on the trip, but it was worth it.

One of the most unique places was the Whale Inn at Goshen, Mass. This is in the heart of the Berkshires, between Northampton and Pittstown, on the Berkshire Trail. We reached there just at dark, after a long drive from New London, through Hartford and up the Connecticut River Valley, through Springfield and Holyoke. This inn is conducted by Miss Mary Lois James, a graduate of Smith College and director of the Smith Alumnae House at Northampton. Miss James is fair, forty and full of energy, and a splendid business woman. She has taken an old farmhouse, 150 years old, preserved in it all that is worth while, built on to the rear kitchens and a long dining porch, and furnished it with real antiques. Every bedroom in the old part of the house has a fireplace—the same fireplace that was built into it a century and a half ago. The old living room, the old dining room and the parlor downstairs have

The terrace overlooking the race track, Goshen Inn, Goshen, N. Y.

splendid fireplaces, that of the dining room being an enormous one, with the old Dutch oven still extant. But, while the furniture is old, there are modern bathrooms, electric lights, and all the comforts of a modern country home. The hotel feature is kept in the background. Incidentally, all the antique furnishings are for sale—even the four-poster bedstead, the highboy, and the fire tongs.

There is a magnificent view of the Berkshire hills. To the west, 35 or 40 miles away, Greylock can be seen if the weather is clear; to the east, Mt. Tom and Mt. Holyoke.

We asked Miss James why she gave it this peculiar name. She said because for a long time there has been a couplet in this countryside about "the whale that swam around on the hill in Goshen". She has modified it slightly, so it now reads—

"A whale swam around the ocean
And settled on a hill in Goshen."

Also, she said her friends told her she had a "whale" of a proposition.

There were few guests at the Whale Inn when we were there, but it is new. I predict that when people from the middle west learn of this delightful place, it will be crowded.

This section has much of interest. Our own Marshall Field was born only eight miles away. The home of William Cullen Bryant is near Cummington, five miles from the Inn.

From Goshen, Mass., we went to Goshen, N. Y., where also there is an Inn (the Goshen Inn). This village is only about 50 miles from New York City, and is settled largely by New Yorkers. The Inn was built by wealthy New York people and is indeed a

Home of William Cullen Bryant, Cummington, Mass.

very delightful place, but quite different from the Whale Inn. It is very quiet, and yet quite modern. We shall never forget our first meal there, on the back veranda, just at dusk, amid the delightful setting of ivy-covered walls and flowers, with the race-track and a pleasant view of the hills to the east. This is one of the best of the modern inns at which we stopped on our trip.

One more I will mention, although I could lengthen this list. We returned home through Port Jervis, Stroudsburg, Bethlehem, Allentown and Gettysburg to Bedford Springs (where there is a fine old summer hotel, itself worthy of a good notice) and from there we turned south to the National Old Trails Highway at Cumberland. On the summit of the

Longfellow's Wayside Inn now owned by Henry Ford.

The hotel at Bedford Springs, Pa.

Cumberland Mountains, four miles east of Uniontown, Pa., at an elevation of 2150 ft. is the Summit House. The nearest village of any importance is Uniontown. This is the hotel visited by President Harding, in the company of Edison, Burbank and Firestone, if my memory serves me right. At this place they spent together several long to be remembered days. There is a magnificent view of mountain scenery, reached after a hard climb over one of the steepest ridges encountered on our entire trip. This also is a thoroughly modern establishment, exceedingly comfortable, and certainly a delight to anyone who enjoys mountain scenery.

I have described these inns, not with a desire to advertise any particular person or place, but hoping that the information imparted may be of help to some other traveler like myself. Every day, and especially along towards the middle of the afternoon, Mrs. Burdick and I kept wondering what kind of place we were going to get into at night. On the whole we were well satisfied, but if we could have had some help like this perhaps we would have had 100 percent satisfaction.

I hope that the suggestions given may be of value to other travelers; also that some of you will write me of your own experiences, either for publication or not, as you may prefer. Sometime my wife and I hope to take another trip through the east, and with the experience gained we hope to make it more pleasant than the first one. Next time we shall not try to travel as far, or cover so much ground. We want to pick out certain of these delightful inns as temporary stopping places, from which we can look the country over more carefully, and devote more time to the places which we have learned to love. New England—indeed, all this eastern territory—is filled with shrines of historic, scenic and literary interest, which every American should visit if he can. To us the journey was an inspiration. It leaves behind many pleasant memories.

A. S. BURDICK.

Chicago, Ill.

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# Gypsy Weather

When ther's a yellow sun on the hill
  And a wind as light as a feather,
And the clouds frisk gayly, as young clouds will,
  Oh, then it is gypsy weather!
That's the weather to travel in,
With the sun and the wind against your skin.
No matter how glad to rest you've been,
  You must go when it's gypsy weather!

The hands of a house can never hold
A man when it's gypsy weather.
A town's too prim and a town's too cold
  For a maid when her heart's like a feather!
Then hark to the words that your pulses say,
And put you hand in my own to-day,
And we'll follow the road as it winds away,
  And we'll look at the world together!

*Mary Carolyn Davies.*

Chicago.

# What Others are Doing

## A CLEAR VIEW OF THE NEISSERIAN INFECTION

In the matter of actually preventing gonorrhea but little has been accomplished. The disease is still widely prevalent. No satisfactory proof is available to indicate that victims are fewer than in the days when prostitutes were segregated. On the contrary, as Wolbarst has quite convincingly shown, we have reason to believe that the disease is as rampant as ever it was.

That nothing has been accomplished in this department of preventive medicine is because the issue has been befogged. What we have heard on the subject has usually come from the physician speaking for the nonce as a purist or as a downright sophist. Seldom has he spoken as a true scientist.

It is, therefore, distinctly refreshing to listen to Dr. Winfield Scott Pugh, (*Medical Times*, July, 1924). In a lecture delivered at the St. Marks Training School for Nurses, he dealt with the subject of prevention in a manner that was singularly straightforward and intelligible.

"Many different orders have been issued by pseudo-brilliant officials to control venereal disease," said he, "such as laws forbidding prostitution or other illicit sexual relations so called. King Canute, with all his pride, could not repel the ocean tide and, where real human nature is concerned, executives are in much the same position as the King. The placing of police in front of suspected houses, or the surveillance of young couples in the hope that they may commit themselves, is useless.

"Most of the reform methods are too stupid to mention. In view of ill-advised legislation, prostitution has been widely distributed from one section of the country to the other. Incidentally, it must be realized that only about 20 percent of venereal disease is from that particular source. No laws will ever reach the clandestines by whom most of the trouble is spread.

"Sexual relations will always take place as long as there is such a thing as sexual instinct, even among those who are so active in proposing laws to prevent them. With the disappearance of the instinct, the human race will soon cease to exist. Scare campaigns are of no value, as I have seen medical students go out for a frolic immediately after attending a venereal clinic where the worst types of cases were seen."

Realizing that it is impossible to prevent illicit sexual intercourse, the writer sees a need for preventives. The condom is a useful if not infallible device in the interest of disease prevention. Calomel ointment is likewise an article of merit in a similar way.

So far as the actual treatment of gonorrhea is concerned, the chief factor, in his opinion, is rest and the use of acriflavine or the silver preparations locally.

## AN ANTIDOTE FOR ARSENIC, BISMUTH AND MERCURY POISONING

Semon (*Brit. Med. Jour.*, April 12, 1924) calls attention to the efficiency of intravenous injections of sterile solutions of sodium thiosulphate for combating the toxic effects of arsenic, bismuth and mercury.

He feels that "we have a specific, safe and rapid antidote for stomatitis due to mercury and bismuth in sodium thiosulphate. It also offers a hope that the course of arsenic poisoning both in the skin and liver can be controlled and in some degree shortened by its administration".

He records two cases of bismuth stomatitis and two of mercurial stomatitis which cleared up very quickly under sodium thiosulphate treatment; also a case of dermatitis following two sulpharsenol injections, in which 0.5 Gram sodium thiosulphate was given immediately with the result that the pruritus disappeared the next morning. There was a slight desquamative reaction 48 hours later, but the patient was quite well in 5 days after two additional injections of sodium thiosulphate.

That we have in sodium thiosulphate an antidote of great value against the toxic ef-

fects of the mineral drugs named, as manifested by stomatitis, dermatitis or otherwise, is the conviction of the writer after ample experience with the agent in the Royal Northern Hospital, London. It is an emergency recourse which physicians generally should have at hand. An antidotal injection prior to giving the arsphenamines, especially when hyper-susceptibility is suspected, might be a wise routine procedure.

Its action is easily explained. It is a purely chemical one, in which the metallic poisons in each instance are converted into harmless insoluble sulphides. The antidote is best given intravenously; its administration by mouth or rectum is less reliable. Only the best quality of drug is to be used and solutions must of course be sterile. For ready application certain pharmaceutical houses are now supplying sodium thiosulphate solutions in glass ampules.

## PITUITARY SOLUTION OUTSIDE OF OBSTETRICS

The uses of a well-selected preparation containing the hormones of the posterior pituitary lobe, outside of obstetrics, are ably set forth in a recent publication (*Ther. Notes*, April 1924).

Such a preparation in therapeutics is mainly valued for its ability to cause contractions of relaxed involuntary muscle, as in the walls of the parturient uterus, the arterial walls, the urinary bladder in cases of abnormal urine retention; or even incontinence, and the distended intestine, as after abdominal surgery.

The physician is so impressed with the effectiveness of a reliable pituitary preparation in obstetrics that he is prone to lose sight of indications other than obstetrical. It is well to recall that it is useful in conditions and emergencies having nothing to do with parturition.

In enuresis nocturna or bed-wetting it has proved very efficient. The much-used atropine is not so effective. Injected under the skin or placed beneath the tongue, it will usually exhibit a controlling effect on the second night; the dose is repeated at two-day to five-day intervals till about six doses are given.

Another important field for such a preparation is diabetes insipidus, which differs from diabetes mellitus in that the excessive quantity of urine passed is of low specific gravity and contains no sugar. As a rule, one or two doses a day will ameliorate the intense thirst, lessen the quantity of urine passed and control the nervousness and other symptoms in a marked degree. The treatment must be continued, however, for lasting effect.

The pituitary and adrenal hormones may be combined to advantage in the systemic treatment of asthma, hayfever, low blood-pressure and shock. The proportions of each in the treatment of a given case may be easily determined if the physician will but remember that the latter lends power to the combination and the former prolongs the duration of its effects.

To the surgeon a reliable posterior pituitary preparation has become almost indispensable. In low blood-pressure, in anaphylactic shock, and especially in tympanites, its beneficial effect is marked. In the latter condition it rarely fails to promote peristalsis, with consequent relief of the dangerous intestinal inflation.

The foregoing are among the more important indications (other than obstetrical) for such a preparation, but its value in certain forms of hemorrhage should not be overlooked. Postoperative bleeding not otherwise controllable will often yield to a pituitary preparation. Metrorrhagia is another indication, though not an absolute one.

Postoperative suppression of urine can usually be prevented or overcome and in the failing heart of diphtheria, pneumonia, etc., it is of decided value. A 1:1000 solution, in 5 to 8-drop doses, is said to be effective in postoperative nausea and vomiting.

## BISMUTH IN THE TREATMENT OF SYPHILIS

Dietel (*Munch. Med. Woch.*, 70, 1250, 1923) employed bismuth preparations in more than 100 cases in all stages of syphilis. In primary syphilis with a negative Wassermann reaction, neoarsphenamine or neosilver-arsphenamine was administered at once, in the attempt to obtain an abortive cure. But, in sero-positive cases, bismuth preparations were first tried to note their influence on the syphilitic manifestations. The author noted that bismuth has a decided influence on the clinical manifestation in all stages of lues, even more favorable than that of mercury. However, its influence on the sero-reaction in all cases where arsphenamine was contraindicated has not been so clear, though in some instances a negative Wassermann was effected with bismuth alone.

The reactions after injections of insoluble bismuth preparations were remarkably few. Most patients felt no pain after injections;

only a few complained of drawing pains for one or two days, and in three cases an infiltrate was observed when the needle penetrated the sites of former injections. No other reactions have been observed.

In summing up, the author states that the results obtained in syphilotherapy with bismuth preparations have been very satisfactory both as to their influence on the disease and the relative absence of reactions. Although he believes that bismuth will never take the place of the arsphenamines, he is of the opinion that it will prove very valuable when combined with the latter or where the arsenicals are contraindicated.

## STERILITY IN THE FEMALE DUE TO SPASM

There is a group of women whose sterility is doubtless caused by spasm affecting the circular fibres of the tubes at the point where they leave the uterus. For the recognition of these cases, one may use the following method proposed by Rubin:

A first transuterine insufflation is done without preliminary medication. If no gas can be made to pass through the tubes, or if gas passes only when the pressure has been raised to 150 mm. or more of mercury, a second insufflation is done a day or so later after the administration of benzyl benzoate. If, on the second occasion, gas passes through tubes previously impermeable, or if it passes at a pressure of less than 100 mm. of mercury in cases in which a high pressure was previously required, we may consider that an obstructive degree of spasm of the tubal musculature has been demonstrated as a factor in the case.

When it is shown by this test that a patient belongs to the group under discussion, and there is nothing else at fault with the wife or husband, then the administration of antispasmodic drugs after coition is indicated for the treatment of sterility, and should give results.

Meaker (*J. A. M. A.*, June 28, 1924), after negative insufflation tests, gave benzyl benzoate in five typical cases. In two cases, he gave five drops of a 20-percent solution every hour for six hours before insufflation; in the others, thirty drops every hour for four hours. In all instances, the constriction was found to be relieved, with gas passing through the tubes under a minimal pressure.

It is hoped that others will carry out these suggestions for overcoming sterility in the female. Benzyl fumarate should be even more effective as an antispasmodic in such cases.

In a small group of patients, transuterine insufflation appears to have also a therapeutic value. Forty or more cases have been reported in which this procedure, undertaken for diagnostic purposes, was promptly followed by pregnancy though no other treatment was given. Three such cases have occurred in the writer's own practice.

As a diagnostic measure, at any rate, it is interesting. If no gas can be insufflated into the peritoneal cavity through the uterus, then we must assume that both tubes are in some way occluded, and the presence of a tubal factor in the case under consideration is definitely established. For, it is clear that a tube which will not permit gas to pass is also impassable for spermatozoa.

## THE BENZYL TREATMENT FOR DYSMENORRHEA

So exceedingly common is dysmenorrhea among females in nearly all parts of the civilized world, and so keen is the suffering in many cases, that a remedy giving relief is one worth its weight in gold, as the saying is.

Physicians were gladdened, therefore, by the announcement of Dr. David I. Macht, of Johns Hopkins University, a few years ago, that certain benzyl compounds are highly effective in that disorder. He first cited benzyl benzoate as serving well in cases of painful menstruation of the spasmodic type, saying:

"I have a record of many cases treated by other drugs, by pessaries and even by curettage unsuccessfully, in which complete relief was obtained after one or two doses."

Other physicians have obtained similar results, although reporting that it failed in some instances to give the desired relief. But, the benzyl treatment is not restricted to dysmenorrhea. As a non-narcotic expedient for relieving pain, the benzyl compounds have proved serviceable in colics proceeding from spasm of the biliary duct, the renal ureters and the intestine; also in tenesmus, as well as the acute distress incident to spasm of the seminal vesicles.

Benzyl benzoate and its allied compounds have proved useful, too, for relieving dyspnea arising from laryngeal and bronchial spasm, in asthma, whooping cough, hiccough, etc., as stated by Seydel (*West Virginia Med. Jour.*, March, 1924).

Nor is the benzoate the last word in this department of therapeutics. Since its advent, chemists have been at work on other compounds of the benzyl series. Quite a number

have been tested in the laboratories and clinics, upon animals and persons, for their antispasmodic qualities. So far, the fumarate seems to be the most effective and reliable, probably because it contains more of the antispasmodic benzyl radical.

## VACCINE TREATMENT IN PRURITUS

Montague, in a paper read at a clinic for rectal diseases at the University and Bellevue Hospital Medical College, and published in the *Medical Journal and Record* (N. Y.), June 18, 1924, recommends vaccine treatment for pruritus ani, along with local measures against the infective focus.

From superficial tissues excised from affected areas, he has been able to culture both the bacillus coli and the staphylococcus albus. This fact suggested the use of a vaccine containing these organisms and from such a vaccine he has obtained very satisfactory results in a quite definite and reasonably large proportion of cases.

He prefers a stock vaccine to an autogenous product made from smears, but has used both. The former, he states, has given better results. He gives it subcutaneously with a small gauge needle, at intervals of one to three days. Even though complete relief from irritation is obtained, the treatment should not be discontinued short of four to six weeks.

## ARSPHENAMINE AFTER EXPOSURE TO SYPHILIS

As the injection of arsphenamine soon after exposure to syphilis in many cases actually prevents the appearance of the symptoms naturally looked for, Simon (*Urol. and Cut. Review*, April, 1924) insists that the procedure is at least in that sense curative. However, it is more to the point to speak of it as being a prophylactic measure.

Local prophylaxis, however, is usually insufficient if used more than twelve hours after exposure, and it is in this group of cases that treatment by arsphenamine is most likely to be of value.

Dr. Simon, who has employed his treatment for the last four years, confines it to persons who present themselves within seventy-two hours after exposure. The application of the method after this time is inadvisable, as there is a risk of giving insufficient treatment to a case in which intensive therapy is required. The patients treated had no previous history or evidence of syphilis, and all gave a negative Wassermann reaction. In most of the cases, signs of active syphilis were present in the paramour.

The method consisted in the injection, every other day for three doses, of 0.3 Gm. neoarsphenamine dissolved in 10 Cc. of distilled water. The Wassermann reaction was examined two weeks after the last dose and then at monthly intervals for four months. In the four cases which Dr. Simon records, the Wassermann reaction remained negative, and no clinical evidence of syphilis was detected in persons so treated who had been kept under observation for periods ranging from four months to two years.

## MILK INJECTIONS IN GENERAL PARALYSIS

The Budapest correspondent to the *Lancet* (June 14, 1924) writes concerning the use of milk injections in general paralysis of the insane. The agent was tried in the clinic of Dr. Moravcsik, director of a large psychiatric institute and lecturer on nervous and mental diseases in the Budapest Royal University, his clinic having a reputation for being strongly conservative.

A patient, suffering from advanced general paralysis, had a carbuncle on his neck, which had been incised and bandaged. The patient, however, had torn off the bandage and smeared the wound with feces, causing an extensive inflammation round the wound with gangrene of the edges. As this condition aggravated his mental state, a surgical specialist was consulted, who recommended the application of milk.

He was given 10 Cc. of sterilized milk under the skin of the abdominal wall on October 19, 1920; the same day he had a temperature of 40° C., which subsided on the following morning. From this time onwards his wound improved rapidly, and his bodily strength began to return. Within one month his wound was totally healed. In December, his mental condition began to improve, his restlessness ceased, his behaviour showed ever-increasing coordination and, on February 21, 1921, he left the clinic quite composed.

The same method was used in 40 cases of general paralysis, many of chorea and several of epilepsy. Dr. Moravcsik stated that he felt justified, in view of the results obtained, in considering milk to be the most efficacious

of the nonluetic therapeutic measures (milk, phlogetan and tuberculin) administered at the clinic, and that the results of milk therapy were much superior to those from antisyphilitic treatment in general paralysis of the insane. He considered milk to be a very valuable addition to the scantily furnished armamentarium against general paralysis. In ten cases of chorea minor the milk protein therapy gave excellent results.

The surmise that the efficacy of the method is probably due to leucocytosis, activation of the protoplasm, stimulation of antibody-forming elements, increased transfusion and hyperemia in the diseased foci, etc., must be confirmed by further and more detailed experiments. Dr. Moravcsik contends that protein therapy should be applied on a wider scale in nervous and mental diseases. The ultimate value of the treatment can only be decided after extensive clinical experiment.

## OPERATING UNDER SACRAL ANESTHESIA

From an exhaustive study of agents employed in this country and abroad for producing sacral anesthesia, Kolischer and coworkers (*Urol. and Cutan. Review,* July, 1924) are convinced that procaine is the drug of choice. A small quantity of epinephrin added thereto enhances its usefulness.

"Some chemical concerns have on the market easily soluble tablets, which facilitate the preparation of this solution."

It is very important, for the success of this method, that in each instance the solution should be freshly prepared and sterilized by boiling in the waterbath. That all further manipulations have to be carried on under the strictest kind of asepsis it is hardly necessary to emphasize.

For sacral injection the patient is placed on one side with the hip and kneejoints flexed at right angles. After the routine sterilization of the skin is carried out, the cornua of the sacrum are located by palpation. In the center of an imaginary line running between the cornua an intradermal injection of the solution is made with a fine needle and small syringe. The small wheal raised this way secures analgesia for the following steps. The small needle is withdrawn and an 18-gauge needle is pushed through the wheal in an oblique direction until the needle point glides over the upper bony periphery of the sacral hiatus. Then the needle is slightly withdrawn. The distal end of the needle has to remain dry. The appearance of fluid at this point means that the dural sac has been punctured. If that be the case the needle has to be withdrawn and reinserted. After a satisfactory insertion of the needle is ascertained, a Record or Luer syringe carrying the anesthetizing solution is attached and the injection is started.

The injection has to be carried on very slowly; at least two minutes should be consumed in this act.

It is paramount to watch the progress of the piston. If any appreciable resistance is encountered, then the tip of the needle is misplaced. It is either within the subcutaneous tissue and no sacral anesthesia will be accomplished, or worse, it may have slipped underneath the periosteum, at which location an injection will cause the patient considerable distress without producing the anesthesia desired.

The investigators view this form of anesthesia as having all the advantages of spinal anesthesia without the distressing and dangerous sequences of the latter.

The untoward complications of spinal anesthesia such as prolonged headache, vertigo, aseptic meningitis, temporary paralysis of the vesical and rectal innervation and even death, any one of which may occur in a certain percentage of such cases, are entirely done away with under sacral anesthesia. The method is said to be quite safe if properly carried out. About fifty percent of all urologic operations are performed on patients of advanced ages who suffer from senile impairment of important organs, such as chronic bronchitis, emphysema, arteriosclerosis and degeneration of various degrees of the heart muscle. In this type of cases, operation may well be done under sacral anesthesia.

## A USEFUL ADJUVANT IN SYPHILIS

Against certain distressing drug effects occurring in the course of antisyphilitic treatment, such as mercurialism and arsenical nephritis and dermatitis, we have in sodium thiosulphate a very useful recourse, according to Drs. Michel and Goodman (*Amer. Jour. of Syphilis,* July, 1924).

Ravaut of Paris was the first to direct the attention of the medical profession to the use of sodium thiosulphate (sodium hyposulphite) in the treatment of dermatitis exfoliativa, which sometimes follows the use of the arsenicals. Corroboration of Ravaut's results have since been obtained by independent workers. The drug is indicated in acute and chronic

arsenic poisoning as arsphenamine jaundice, dermatitis, etc.,; in acute and chronic mercurial poisoning, as bichloride intoxication and mercury stomatitis. Other forms of metallic poisoning as from lead, copper and zinc are amenable to this drug.

The mode of administration may be either intravenous or oral. In arsenic poisoning the following method has been recommended: one Gram three times a day by mouth after meals, and intravenously in from 10 to 20 Cc. of sterile distilled water each day for the first four days, 0.3, 0.45, 0.6 and 0.75 Gram; and then every other day for the next four days, 0.75, 0.9, 1.0 and 1.0 Gram. Usually from four to six doses are sufficient, but if the condition of the patient demands longer treatment, the physician need have no hesitancy in continuing it. One-Gram doses intravenously in the period after the administration of the first eight doses seem to be indicated. Locally, in exfoliative dermatitis, the affected area should be anointed with olive or sweet oil in which has been dissolved a little gum tragacanth. Whenever possible the patient should be exposed to the sunlight or to the artificial sun-lamp. Also and in all cases, the patient should be kept warm.

In mercurial poisoning, sodium thiosulphate solution may be used to lavage the stomach, and intravenous introduction should be much more intensive, 0.45 Gram at once, followed in four hours by 0.9 Gram and eight hours later by 1.0 Gram. Intravenous injections of 1.0 Gram every day should be continued until the patient is fully recovered. Ordinary mercurial stomatitis is relieved by the injection on alternate days of 0.45 Gram of sodium thiosulphate until from two to four doses have been administered. Oral administration should also be carried on.

## CALCIUM TREATMENT FOR EDEMA

Drs. Rockwood and Barrier report having used large doses of calcium (from 12 to 18 Grams daily) in cases of massive edema of diabetic and nephritic origin.

In six of seven cases, most of which had been resistant to other methods of treatment, edema disappeared completely. In one case, edema disappeared but the part played by the calcium is questionable. In two cases of nephritis edema recurred later. None of these cases were complicated by significant myocardial damage, and in none was any other diuretic given with the calcium. In the few instances in which we used small doses of calcium (from 1 to 3 Grams daily) little or no effect was observed.

In some of the cases edema was reduced by calcium lactate. In other cases calcium chloride seemed more effective. Large doses of calcium do not seem to increase the amount of serum calcium. In one case of diabetic edema, a considerable rise of the basal metabolic rate was observed.

A similar dose of calcium did not produce a change in the basal metabolic rate of a normal person. In the other cases of edema discussed, the administration of calcium had no effect on the basal metabolic rate. The high calcium content of milk may explain its diuretic action, and thus its popularity in the treatment of acute nephritis.

Calcium chloride as the ordinary dry salt is difficult to take and frequently causes gastrointestinal disturbance. It would seem best on this account to give it intravenously, for which ampule solutions are available.

While the good offices of calcium against edema have been observed repeatedly, by these and other investigators, the way in which it acts is not clear. Hulse, reporting eight cases of nephritis with edema successfully treated by 15 to 20-Gram doses of calcium chloride, assumes that in some manner the calcium frees the sodium chloride and water that is held by the tissue colloids. He found that, along with visible reduction of the edema in his cases, there was also improvement in the renal function.

## A NEW TREATMENT FOR EPIDIDYMITIS

According to Cerf (*Ther. Gaz.*, Mar. 15, 1924), intravenous injections of calcium chloride solution are highly useful in the treatment of epididymitis.

He found it efficacious in a series of 17 cases, all being ambulatory but one. With one exception, each patient received 10 Cc. of a 10-percent solution intravenously, with a repetition of the dose every three days. The greatest number of injections given in any single case was five. In seven cases two injections were given, and in five cases only one injection was necessary. In all instances, the patient was advised to wear a suspensory padded with cotton. Hexamethylenamine, 7½ grains, three times a day, was prescribed.

During the course of the injection, the patient usually experiences a sensation of warmth in the mouth, followed by a feeling of heat

generally over the body. The sensation lasts for several seconds and is usually followed by a sedative effect. It is well to advise the patient beforehand as to the sensation he may experience so that he may feel no uneasiness. In eleven of these cases the pain subsided absolutely within a half hour, and in the remainder it disappeared within two hours after the injection. The temperature is immediately affected in that it falls rapidly.

Cerf considers calcium chloride in 10-percent solution, given intravenously in 5 or 10 Cc. doses, quite harmless. How does the drug act? Briefly, it appears to increase phagocytosis with a hastened absorption of exudate and a rapid subsidence of testicular swelling.

## EXPERIENCE WITH NEOCINCHOPHEN IN ACUTE RHEUMATISM

Reporting the results from the use of neocinchophen in twenty cases of rheumatic fever, Drs. Boots and Miller (*Jour. A. M. A.*, Mar. 29, 1924) write as follows:

"In recent years, several favorable reports have appeared on the use of cinchophen (phenylcinchoninic acid) and its derivatives in the treatment of arthritis. Originally recommended as uric acid eliminants in gout, these drugs were found to be effectual in the relief of the polyarthritis and pyrexia of rheumatic fever. One of the derivatives, the methyl ester of para-methylphenylcinchoninic acid, besides having antirheumatic properties equivalent to those of phenlycinchoninic acid, has the additional advantage of being tasteless and nonirritating to the stomach."

The object of the investigation in the main was to compare the action and effects of this newer drug with those of the salicylates, as represented by the sodium salt. In general they act quite similarly as antipyretic and antiphlogistic agents, it was found. Sodium salicylate gives satisfactory symptomatic results in most cases of rheumatic fever. Neocinchophen, on the other hand, is useful in some instances in which the salicylates fail to relieve the symptoms completely or the patient is so susceptible to their toxic effects that sufficient therapeutic doses cannot be given. However, it may be necessary to administer somewhat larger doses of neocinchophen than of salicylates to obtain similar clinical results. This brings up for consideration the cost of treatment with the newer drug, but if less toxic and equally or more effective the cost is relatively unimportant.

The conclusion arrived at by the investigators is that neocinchophen is the less toxic. In view of this, it would seem wise to prescribe it in most if not all cases.

The matter of toxicity was carefully considered. While finding a low relative toxicity for neocinchophen, the investigators, nevertheless, do not agree with Barbour and Lozinsky that experiments with dogs can be used as an infallible guide to dosage in febrile cases, and they consider it unsafe to rely on the selective power of the human intestine to absorb only enough of the drug to relieve the patient of pain and fever.

The drug, they contend, is to be prescribed with a reasonable degree of circumspection. Since a few persons appear to be hypersensitive to the drug and since it is capable in people with unsound kidneys to further irritate these organs, it is recommended that the urine be examined occasionally during its administration.

At the same time, one gets from this report the impression that the drug is very well tolerated by the average patient. Drs. Boots and Miller gave large doses—from 4 to 17 Grams each 24 hours—although they took care to stop the drug at the first appearance of toxicity, in which case it was resumed next day. The total amount given from the start to the end of treatment varied from 21 Grams (in 3 days) to 440 Grams (in 118 days).

The urine in all cases was watched for signs of renal irritation. It is significant that when albuminuria appeared in the first part of the treatment, in most of the cases it disappeared as the treatment progressed.

More than half of the patients were permanently relieved; the others received incomplete or transitory relief.

## COCAINE SOLUTIONS IN THE NOSE

A warning against the use of cocaine solutions in the nose appears in the *Journal of the American Medical Association* for April 19, 1924.

A reader, having a patient with hyperesthetic rhinitis who has been resorting to cocaine sprays for relief, wants to know if the procedure may be continued with safety. The editor's reply is in the negative, thus:

"It is a dangerous practice to allow any patient to use even a diluted solution of cocaine for any length of time in the nose. The tendency to the formation of the cocaine habit is great and is to be avoided. The use of the epinephrin chloride and a 1-percent procaine solution, with physiologic sodium chlo-

ride solution, often gives considerable relief; or the use of an oily solution, in which about 0.1 Gram of menthol to 30 Cc. of liquid petrolatum is employed, frequently gives as much relief as will the cocaine and will be entirely deviod of all serious consequences.

"No patient should receive prescriptions for cocaine solutions to be used by himself.

"Often the use of calcium chloride or calcium lactate is about 0.5-Gram doses three or four times a day helps materially in diminishing the symptoms accompanying a hyperesthetic rhinitis. At times a hyperplastic ethmoiditis is present, which accounts for many of the symptoms; and while that operation should be used only as a last resort, there are cases in which the opening of the anterior ethmoid cells, or possibly also the posterior ones, is indicated when all other measures have failed."

## A TREATMENT FOR GONORRHEA

If the patient is seen early—in the first 24 to 48 hours—it is fair to attempt an abortive form of treatment with reasonable expectation of success, and it is in these cases that acriflavine provides us with valuable aid. It may be employed as an injection or irrigation.

The following plan is successful: The anterior urethra is thoroughly irrigated with a solution of acriflavine, 1:4000, beginning with a very gentle stream, and later using sufficient force to balloon the urethra and thoroughly clean out the folds and crevices in the mucous membrane. The solution is then forced past the cut-off muscle through the deep urethra and into the bladder. The patient voids this immediately and a few ounces of the solution are again forced into the bladder with an irrigator and the patient is instructed to retain this for one hour. This treatment is supplemented by a sample anterior injection of acriflavine, 1:1000, which the patient uses at home twice daily.

If all goes well, the irrigations are given daily for the first week and every other day for the second week. Gonococci will often disappear after the first two or three treatments, discharge may be absent and the urine clear a few days later. By the middle of the third week, if there are no symptoms, the anterior and posterior urethra is irrigated and a 26 French sound passed to the bladder, followed by another irrigation. If the urine is clear, the following day, treatment is discontinued and the patient is instructed to report at intervals for the next week.

At each visit the genitals should be inspected and the patient instructed to urinate in two glasses. If the second glass is turbid and if we find in addition symptoms of frequency, tenesmus, and nocturia, all local treatment should be discontinued. More errors are made at this time than at any other. Insistence upon the use of injections and irrigations at this time spells disaster. The local treatment should be resumed only when the acute posterior urethral involvement has entirely subsided. There may come a time when the patient is free from symptoms except for a slight pale mucus discharge. If this is free from gonococci—which emphasizes the necessity of the microscope—all treatment may be discontinued for a while, or a simple astringent injection prescribed. The average course of this group of cases is from six to twelve weeks.

In chronic gonorrhea restore the urethra to its normal calibre by gradual dilation, and massage the prostate and vesicles until areas of exudate have been absorbed and the smear is free from pus cells. This dilatation should be followed by an anteroposterior irrigation of silver nitrate varying in strength from 1:1000 to 1:10,000. The massage should be preceded by an irrigation, filling the bladder with the solution and allowing the patient to void after the massage.

Do not dilate and massage at the same sitting. Dilate the urethra gradually and do not divulse it. If the smaller stricture measures 22 French, begin with a 23 sound, and if there is no bleeding or extensive reaction, try a 24 sound, four to seven days later. The average patient should be treated about twice weekly, massaging and dilating at alternate visits.

The foregoing is the method carried out by Rathbun, as described in the *Urologic and Cutaneous Review*, Feb. 1924.

## A STUDY OF IODINE

The action of this drug upon the thyroid gland has been subject to more study than any other feature, write Boyd and Nash (*Jour. of the Amer. Inst. of Hom.*, Aug. 1924). The more direct relationship between iodine and the thyroid has been reported by various writers during the last twenty years. For example, several observers have been able to correlate the architectural structure of the thyroid with the iodine of the gland. This is a parallelism between the colloid content and the iodine content.

The action on the ovaries has always been

questioned. Many authors have mentioned the point that it is an emmenagogue. On the other hand, Mansen has definitely denied the drug having this action. The most conclusive evidence offered is the experiment of Jastkaam. He began using six thousandths Grams of iodine per kilogram and increased the dose, observing the following effect in sixty-four animals. The epithelia showed a poverty of nuclei and there was no discernable effects upon the vesicular elements, proving that iodine has a deleterious effect upon the sexual organs. Admitting the effect of iodine in the treatment of dysuria, Greumme still sees the effect as being the result of the action produced through the thyroid.

Other glandular structures are also involved in iodine intoxication. The parotid gland in particular has been incriminated in a number of instances. Groen produced acute parotitis in eight cases and Fuerth has mentioned an acute idoism simulating mumps. These writers seem to have overlooked, many years ago, that Lowrie pointed out inflammation of the salivatory glottis and adjacent parts as occurring in iodine intoxication.

The action of iodine upon the respiratory apparatus has been known ever since iodine was discovered. One hundred years ago, Jorgan described the increase of nasal mucus. Later, bloody pleural and pulmonary exudate, together with renal congestion and hemorrhage, were mentioned. The recent World War showed that the action of iodine was known throughout the world and recently it has been pointed out that iodine produces dyspnea due to an acute inflammatory reaction of the lungs manifested by an acute pulmonary edema. There is a rise in blood-pressure and acceleration of rate and increased amplitude of respiration. It may be rather surprising to note that iodine has been used with success in the treatment of pulmonary tuberculosis, and as a therapeutic and prophylactic agent in acute infectious disease of the upper respiratory tract.

The action on the nervous system has been indicated in the preceding paragraphs. However, it may not be amiss to point out that convulsive actions are not unknown. This seems to involve the muscle extremities. Gairdner has mentioned this as well as the extraordinary emaciation. The patients are fleshless, have anxiety, depression and tremors and their gait is tottering and uncertain.

There still remains two actions to be mentioned. The action upon the skin may be of a purple ecchymotic nature with pemphigoid bullæ or bullus formation. Cases have been described where intracutaneous application has given rise to intense itching and burning of the skin, the sensation of swelling of the face and hands, wheals on hands and arms or a typical urticaria of the face, scalp and upper extremities and of a lesser degree of the lower. It is surprising that a small dose may sometimes cause a rash and a large one does not.

The other actions that should be indicated even in a brief review are those upon the joints and disease-producing bacteria. It seems to have a decidedly beneficial action in cases of arthritis and it seems to the authors to be best in those cases where the arthritis is secondary to gastrointestinal disturbance.

In addition to its well-known antiseptic action, iodine seems to cause favorable changes in resistance. Leonardo states that iodine raises the opsonic index.

# Among the Books

## CROFTON: "ENDOCRINOLOGY"

An Outline of Endocrinology. By W. M. Crofton, B. A., M. D., Lecturer of Special Pathology, University College, Dublin. Edinburgh: E. & S. Livingstone. 1924. pp. 122. Price 6 shillings net.

In this Outline, the author desired to produce a short but sufficiently comprehensive textbook, not only for the medical student but also for the general practitioner. A careful reading of the text impressed the Reviewer with the thought that this purpose had been accomplished excellently. As far as they are known, the functions of the various glands with internal secretion have been described accurately. Also the clinical evidence of endocrine disturbance has been discussed in such a manner that the practitioner will receive guidance for his therapeutic procedures.

In the employment of endocrine substances for therapeutic purposes, it must be somewhat disconcerting to certain laboratory men and theorists to find one of their own class who, however, is also a clinician, cooly set aside their dicta and recommend the administration of several of these substances by mouth. Dr. Crofton had better take heed or he will be sent to Coventry. However, to us it is very reassuring to find (p. 20) that whole-gland substance (pituitary) given by mouth is one of the best tonics the author knows; that, in pregnancy (p. 23), if there is a history of uterine inertia, or if the mother is asthenic towards the end of pregnancy, pituitrin should be given by mouth to increase the general tone and the tone and sensitiveness of the uterus; that (p. 35), in asthma, 5 grains of the desiccated suprarenal gland may be given by the mouth, three to six times a day, although 2-grain doses of pituitary substance are considered better for the purpose, by the author, as it is for wheezing in bronchitis.

With all this daring and outspoken practical therapeutics, the author is by no means fatuous in his enthusiasm regarding the possibilities of endocrine therapy. He voices a warning against uncritical employment of the remedies. On page 120, we read: "It has been stated by enthusiastic endocrinologists that the future of therapy depends on the further development of treatment by hormones, that all disease could be overcome apparently by the giving of hormones. This, of course, is not the case. The glands of internal secretion furnish us with drugs of precision, but the giving of them can only help the body in so far as they restore it to physiological normality and so enable it to produce antibodies, and allows the process involved in their action to take place with efficiency. . . ." Fortunately (p. 122), "Combinations of extracts having general restorative and specific effects can be obtained commercially and are often very effective. . . . It is well to remember that the giving of an endocrine extract acts not only by adding to the content of the body in that substance but also stimualtes the gland that ought to produce it to do so."

These remarks are good enough for an editorial. May be, they will afford us a text for a preachment, one of these days. Anyway, we have enjoyed reading Crofton's book and, more, we have benefited from it.

## OCHSNER: "FATIGUE INTOXICATION"

Chronic Fatigue Intoxication. A Heretofore Inadequately described Affection. By Edward H. Ochsner, B. S., M. D., F. A. C. S., New York: G. E. Stechert 1923. Price $2.50.

Some years ago, we were keenly interested in certain experiments in which animals were subjected to great fatigue, through effort, when it was found that toxic substances had formed in the muscles which received the name of kenotoxin. During the war and since then, the problem of undue fatigue has received a fair amount of attention, it having been shown that, in the industries, the driving of employes to the point of overfatigue not only fails to speed up production but that it rather lowers both quantity and quality of the output.

Some physicians have given a good deal of attention to this subject, and we owe thanks to Doctor Ochsner for having crystallized the extant knowledge on it in so excellent a man-

ner. No doubt, in many instances of obscure invalidism, the various customary lines of clinical search leave us unsuccessful, and our patients fail to respond to treatment directed against a possible focal infection, a supposed endocrine imbalance, and so on. Then it is fully worth our while to inquire whether there be not, by chance, a possibility of habits that have created a condition of chronic fatigue intoxication with all its attendant ills. A recognition of this factor, where it exists, and a proper therapeutic procedure in accordance with the diagnosis will, many times, bring results where, without it, failure will be our portion.

Dr. Ochsner's argument is convincing; his descriptions are lucid and helpful. His book should be studied especially by our colleague, the general practitioner. It enters into the subject of fatigue poisoning in a practical manner that makes it possible for us to appreciate the seriousness and importance of the affection, to recognize it when we see it clinically, and to deal with it correctly. A detailed account of the contents is given on p. 598 of this issue of CLINICAL MEDICINE, to which we refer the reader.

## "OXFORD INDEX OF THERAPEUTICS"

The Oxford Index of Therapeutics. Edited by Victor E. Sorapure, M. D., F. R. C. S. (Edin), Henry Frowde and Hodder and Stoughton, Bedford St, London. Price: $12.00.

The editor, in his preface, states that "the purpose of this work is to extend the interchange of ideas and of the methods of practice of each of the great branches of the English-speaking practitioners of medicine." As Doctor Sorapure, for over a decade, taught and practiced medicine in New York, he naturally has had excellent opportunities to judge not only the interests but also the *needs* of both peoples.

A most successful attempt has been made to present the best (accepted) method of dealing with each condition considered. For convenience the work has been divided into four sections. Part 1, The Methods; Part 2, The Agents; Part 3, A Pharmacological Summary of the Agents; Part 4, The Index.

The monographs in part one—all by men of unquestioned ability—are arranged in groups wherever the clinical relation justifies such procedure. Other topics on Medicine, Minor Surgery and Clinical Methods not germane to each other stand by themselves in the alphabetical order of the main groups. Every therapeutic agent mentioned by a contributing editor is considered in part two. Every preparation which is in either the British or American Pharmacopeia is given its official name and compared with corresponding preparations, official or nonofficial. Dosage, valuable hints on prescribing, information as to solubility, toxicity and so forth are given, and new agents mentioned, printed in bold-faced type.

Sorapure's Textbook of Therapeutics is not only an invaluable reference book but a volume which may be read *with* advantage by the practitian who wishes or needs *must* be *au courant* with Medicine as practiced today.

## McCANN, "CALORIMETRY IN MEDICINE"

Calorimetry in Medicine. By Wm. S. McCann; Associate Professor of Medicine, and Associate Physician, Johns Hopkins Hospital. Baltimore: Williams & Wilkins Co. 1924. Price $2.25.

This is Volume IV of a series of books entitled Medicine Monographs. The author has attempted, quoting from the preface, "to point out the broader fields of usefulness of calorimetry in medicine, in the belief that those contributions are of most lasting value, which add to the better understanding of the mechanism of symptoms and of the action of therapeutic agents."

The book, with its 98 pages, is necessarily limited in its detail. The reader will find the conclusions of the various workers in this field concisely, but clearly, stated. And in all cases the workers' names are given in the text as well as a reference number to the very complete bibliography, which is appended to the book.

The book is divided into four parts: Part I, The basal metabolism; Part II, The effects of the ingestion of food on the metabolism in disease; Part III, The mechanical efficiency of the body; Part IV, Total energy requirements in disease.

The use of mathematics has been limited to essential formulae. The book is very readable, the one criticism being the absence of an index.

## BISS: "BAILLIÉRE'S POPULAR ATLAS"

Baillières Popular Atlas of the Anatomy and Physiology of the Male Human Body. By Herbert E. J. Biss, M. A., M. D., Cantab. D. P. H. Third Edition. Plates by Georges M. Dupuy, M. D. New York: Wm. Wood & Co. Price $2.00.

This Atlas of Anatomy differs from many others in the essential fact that the "descriptive text" is descriptive and the information the average man desires when he consults an atlas, uniformly forthcoming There is, of course, nothing startling or novel about the plates; but, then, we have had no startling or novel anatomical revelations, even in this period of rapid changes and new things. Every plate is trustworthy, the markings are correct and one can refer to Ballière without danger of being betrayed. It is just right for the office desk drawer.

## STEVENS: "THERAPEUTICS"

Text-Book of Therapeutics inculding the Essentials of Pharmacology and Materia Medica. By A. A. Stevens, M. D., Professor of Applied Therapeutics, University of Pennsylvania, Philadelphia. Sixth edition, entirely reset. Octavo of 793 pages. Philadelphia and London: W. B. Saunders Company, 1923. Cloth $6.25 net.

It is unnecessary to commend Stevens. Virtually every man practicing medicine is familiar with the work and, "If you find it in Stevens, it's so," has become an axiom. The advances in pharmacology and applied therapeutics have, of course, necessitated many changes and the Reviewer notes that several articles dealing with important remedies have been entirely rewritten. Benzyl benzoate, papaverin, thyroxin, thromboplastin, mercurochrome, aluminum chloride (the essential ingredient in practically all the advertised "odorless personality" preparations), barbital, cinchophen, the chloramines, surgical paraffin, carbon dioxide snow, the arsphenamine, acriflavine and proflavine. These and many others are dealt with fully and for the first time.

Brought up to the hour, this sixth edition of Stevens presents a concise description of every recognized drug, its pharmacology and therapeutic application. The section devoted to Applied Therapeutics is particularly informative.

To the practicing physician the book is a *necessity.*

## BLANCHARD: "AMBULANT PROCTOLOGY"

An Epitome of Ambulant Proctology. By Charles Elton Blanchard, M. D. Author of "The Letters of Dr. Betterman," etc. Youngstown, Ohio: Medical Success Press. 1924. Price $5.00.

Ambulant proctology seems to occupy somewhat the same position, today, that was held by electrotherapy, about forty years ago, when it was relegated into the realm of quacks and charlatans. It took a good bit of courage and perseverance to raise electrotherapy out of the slough of discredit into which it had fallen. Likewise, much unjustified prejudice had to be overcome to establish genitourinary practice as a reputable specialty (as the late Dr. Frank Lydston often remarked, to his friends), and now the same seems to happen in the case of proctology as viewed entirely as an office, or ambulant, practice. At least, those men who have the hardihood to assert that most radical operation on and about the rectum are unnecessary, are spoken of in very uncomplimentary terms.

Not that we wish to take sides in the dispute, either way. We are reminded of the remark (in another connection) that we have friends in both places, and we think well of them both. Still, we deem it only just to give to the author, an ardent advocate of the methods in question, a hearing. His book is interesting not only because of the proctologic information that it affords. We like his blunt, homely philosophy. It reminds us of "Dr. Betterman" for whom we conceived a cordial liking, more than a dozen years ago. So, we say, get the book, by all means. If you do not care to go in for proctologic office work, you are the loser, financially, we have no doubt. However, you will be sure to benefit by whatever else you find in these pages.

## CROWTHER: "PRACTICAL PHYSICS"

Practical Physics. By J. A. Crowther, Sc.D., F. Inst. P. London: Oxford Medical Publications 1922. Price $3.25.

Here is a book designed to cover the practical work in physics which the medical student is usually expected to know. It is really practical. Only the fundamental principles of physics are discussed, but these are covered in a very precise and exact manner. A brief but pointed discussion of general principles precedes each of the experiments outlined and, throughout the entire work, the importance of accuracy is emphasized.

## BURNHAM: "BUILDING YOUR OWN BUSINESS"

Building Your Own Business. By A. C. Burnham, B. S., LL. B., President, The Brodie Burnham Company. New York: The Ronald Press Company. 1923.

This is a book that can be profitably recommended to anyone who is considering a career in business. The author recognizes the fact

that, in recent years, there have been no books containing information on how to find, operate, and finance a small business. Much has been written on "big business," biographies of "captains of industry," etc., but nothing has appeared that would be of much help to the average individual whose greatest chance for success lies in developing a small independent business.

The author supplies this need by a study of 56 case histories of businesses which are owned entirely or largely by the originator, that were started with little or no capital and have developed to a point where they are capitalized at from $20,000 to $5,000, and pay the owner from $5,000 to $25,000 yearly. The essential principles of selecting, planning, organizing, operating and financing a business are disclosed by a study of the data in these first-hand reports. It is a most convincing and interesting manner of presentation and results in a book that is of unusual interest to a person contemplating entering business or to the father with a son who is attempting to choose a career.

## GABELL: "PROSTHETIC DENTISTRY"

Prosthetic Dentistry. A Textbook on the Chair-Side Work for Producing Plate Dentures. By Douglas Gabell, L. R. C. P., M. R. C. S., L. D. S. London: Oxford Medical Publications. 1921. Price $4.00.

While intended, as the author states, "firstly for inexperienced students", it requires only a casual survey of this book to see that it contains much of value to the practicing prosthetist. It deals "with the chair-work for fitting ordinary dentures in the natural order of such work." Ordinary dentures are the kind which constitute about ninety-nine percent of the denture cases of the average general practitioner, and by far the majority of cases handled by the prosthetic specialist.

Physically, the book is handy as to size; type is large and easily read; illustrations frequent and clear. It should make an excellent textbook for the student and a convenient source of review and reference for the practitioner. Physicians desiring to post themselves on such matters in order to cooperate more efficiently with their dental brethren will find this book easily understandable.

## PRICE: "PRACTICE OF MEDICINE"

A Textbook of the Practice of Medicine. Edited by Frederick W. Price, M. D., F. R. S. (Edin). Henry Frowde and Hodder and Stoughton, Bedford St., London. Price: $10.00.

This book almost surpasses the admittedly high standard of the Oxford Publications. The editor, rightly deeming that now more than ever is beyond the scope of any authority, (however varied his range of knowledge) to do full justice to the ever-widening field of medicine, and that a useful purpose might be served by the publication of a work of moderate compass and in one volume, in which the different branches of medicine were dealt with, has sought the services of authors who have made a special study of each. It has also been thought advisable to include sections on diseases of the skin and psychological medicine. Tropical diseases are also included.

In order to secure greater uniformity of method and style, the principle of allotting a whole section to one author has been accepted.

Among the contributors are such well-known authorities as Adie, Beaumont, Craig, Graham, Horder, Hutchison, Hurst, Price and Willcox.

The Index, as usual, is most complete and very materially aids the busy practician in finding the information he needs.

## COLEMAN: "MATERIA MEDICA"

Notes on Materia Medica, Pharmacology and Therapeutics for Dental Students and Practitioners. By Frank Coleman, M.C., L.R.C.P., M.R.C.S., L.D.S. Fifth Edition. London: Oxford Medical Publications. Henry Frowde and Hodder & Stoughton. 1922. Price $3.25.

This is the fifth edition of this work of notes on Materia Medica, Pharmacology and Therapeutics for dental students and practitioners, it first having been published in 1902.

This book has been entirely rewritten and recast.

The action of drugs and their therapeutic properties have been more fully described and fuller information has been given on vaccine therapy and the gland extracts. A short account of collosols, ethanesal, artificial hyperemia, organotherapy, electrotherapy and radiotherapy has been introduced and brief reference has been made to recent subjects, such as delayed chloroform poisoning, detoxicated vaccines, and vitamines. An abstract of the new Act relating to the prescribing and sale of poisonous drugs has also been included.

On the other hand, the chapters on ionic medication and on the bleaching of teeth have been abbreviated and the therapeutic index omitted.

The result has been to keep the book of much the same size as in previous editions, although much new matter has been added and the remainder revised in every detail up to the present date.

## "THE NATIONAL HEALTH SERIES"

Four more numbers of this series have appeared since the discussion of the first ten in the June issue of CLINICAL MEDICINE. They are as follows:

"Love and Marriage. Normal Sex Relations." By Thomas Walton Galloway, Ph.D., Litt. D. Associate Director Department of Educational Measures, American Social Hygiene Association, New York.

It has frequently been stated that the present age excells in things mechanical but is unusually inferior in the finer art of satisfactorily solving the more difficult problems of human relations. Such books as this should greatly help in overcoming this later deficiency. This is a book that can safely be put into the hands of the adolescent boy and girl. It discusses the facts of life in a fundamental manner and, at the same time, instills in the mind of the reader an appreciation of the true happiness that can be attained by a proper development of the relationships of marriage.

—

"The Expectant Mother; Care of Her Health." By R. L. DeNormandie, M. D., Specialist, Boston, Mass.

Here is another book on this much discussed and ever-present subject. It is a model of brevity. The arrangement of the material is excellent.

—

"Tuberculosis; Nature, Treatment, and Prevention." By Linsly R. Williams, M. D.; Managing Director, National Tuberculosis Association.

This book contains all of the information that the average layman would desire on the subject. And it is a subject that is apt to come within the immediate experience of almost any individual at some time or other. Perhaps the most important chapters in the booklet are those on the prevention of tuberculosis and the antituberculosis campaign.

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"Venereal Diseases; Their Medical, Nursing and Community Aspects." By W. F. Snow, M. D., General Director, American Social Hygiene Association.

Another booklet most excellently written. The subject is discussed in a dignified and highly informative manner. Much emphasis is placed upon the various lines of attack that should be followed in combating the venereal diseases and a very comprehensive campaign is outlined. The author wisely avoids any mention of prophylaxis.

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"The National Health Series" is a collection of twenty small volumes (pocket size) containing an average of only seventy pages of text and dealing with the main problems of health, presented in such a manner as to be of service to the laity. The volumes have been prepared under the auspices of the National Health Council and are published by Funk and Wagnalls Company, New York and London, at the price of $6.00 net, for the set, 30 cents per volume.

## BICKHAM: "OPERATIVE SURGERY"

Operative Surgery. Covering the Operative Technic Involved in the Operations of General and Special Surgery. By Warren Stone Bickham, M. D., F. A. C. S. In six volumes. Volume II. Philadelphia and London: W. B. Saunders Co. $10 per Volume.

We have reviewed the first volume of this encyclopedic work in the preceding issue and, at this time, said something about the general scope and character of this work.

The present, second, volume contains nearly 900 pages of text and very numerous illustrations. Operations upon the blood vessels, lymphatic gland and vessels, nerves, plexuses and ganglia, bones, joints, muscles, tendons, ligaments, cartilages, bursae and fascia are dealt with in twelve chapters constituting the bulk of the volume.

In this volume begins the third part of the entire work, containing two chapters devoted to operations on the skull and brain and to operations upon the spine and cord, these two chapters alone constituting a little less than one-half of the volume.

The volume is replete with information on the subjects under consideration, so that the surgeon seeking to refresh his mind on any one or all operations involving the organs or structures dealt with in this volume will find all he seeks in these pages. This volume is as highly creditable as the preceding one.

# Current New Literature

**To assist doctors in obtaining current literature published by manufacturers of equipment, pharmaceuticals, physicians' supplies, foods, etc., CLINICAL MEDICINE will gladly forward requests for such catalogues, booklets, reprints, etc., as are listed from month to month in this department. Some of the material now available in printed form is shown below, each piece being given a key number. For convenience in ordering our readers may use these numbers and simply send requests to this magazine. Our aim is to recommend only current literature which meets the standards of this paper as to reliability and adaptability for physicians' use.**

**Both the literature listed below and the service are free. In addition to this, we will gladly furnish such other information as you may desire regarding additional equipment or medical supplies. Make use of this department.**

I- 21 Surgical Operations, for the Surgeon and General Practitioner. Dr. R. B. Waite.

I- 22 Biological Products for Human Use—with Indications for Use, Dosage, Price List, etc. Gilliland Laboratories.

I- 24 Glandular Preparations. 16-page booklet put out by Drug Products Co.

I- 28 Grape Juice as a Therapeutic Agent. An attractive book published by The Welch Grape Juice Co.

I- 29 Oral Health, and the Relation of Diseases of the Teeth and Gums (Pyorrhea) to Diseases of the Body. 24-page booklet by the Dentinol & Pyorrhocide Co.

I- 30 Helping the Cell to Help Itself. 32-page booklet by "The Alkalol Co."

I- 32 Local Inflammation and Its Rational Treatment. 16-page booklet by The Dionol Co.

I- 45 Treatment of Chronic Prostatitis by Electro Therapy, by W. B. Chapman, M. D. 6-page folder. H. G. Fischer & Co.

I- 49 "Vichy" Natural Mineral Waters. Henry E. Gourd.

I- 51 Treatment of Syphilis. 32-page booklet by Dermatological Research Laboratories.

I- 58 Symposium on Yeast. 24-page booklet. The Fleischmann Co.

I- 69 Gonosan. 4-page folder by Riedel & Co.

I- 71 Goitre Special. 4-page folder by Columbus Pharmacal Co.

I- 80 Allonal "Roche." The Non-Narcotic Hypnotic and Analgesic. 8-page booklet by Hoffman-LaRoche Chemical Co.

I- 84 Storm Binder and Abdominal Supporter. 4-page folder by Dr. Katherine L. Storm.

I- 90 Sklar's E. N. T. Specialist's Outfit. 3-page folder by J. Sklar Mfg. Co.

I- 91 The Colden Way. 8-page booklet by Century Nat'l Chemical Co.

I- 98 Peptone Solution. As an Aid in Immunization and Desensitization, by Armour & Co.

I-101 Bulletin No. 119. Surgical Instruments, Equipment and Supplies for Physicians and Hospitals. A. S. Aloe Co.

I-103 Therapeutic Use of Chlorine in the Treatment of Respiratory Infections. No. 61. 8-page folder by Wallace & Tiernan.

I-104 Petrolagar (Deshell). What It Is. 8-page booklet by Deshell Laboratories.

I-121 Semi-Curette and Uterine Evacuator by Huston Bros. Co.

I-124 Prescribed Diet. Kellog Co.

I-134 Chinosol—Non-Poisonous Antiseptic. 32-page booklet by Parmele Pharmacal Co.

I-147 Eco Products—Thermometers, Needles, Syringes, Elastic Bandages and Veterinary Products. Eisele & Co.

I-148 A, B, C of Taylor Massotherapor. 24-page booklet. Cairnes & Co.

I-149 Continental Scale Works. 24-page booklet. Continental Scale Works.

I-150 Price List—Pharmaceutical Dept. 8 pages. Armour & Co.

I-151 Obstetrical Charts, in colors. Battle & Company.

I-152 Ace Bandages. 4-page folder. Becton, Dickinson & Co.

I-153 The Aseptic Syringe. Becton, Dickinson & Co.

I-154 Cadechol an Organic Camphor Compound. 4-page folder. Ernst Bischoff Co.

I-155 Bilival. 4-page folder. Ernst Bischoff Co.

I-156 Facts Worth While Concerning Free Iodine Therapy. 8-page booklet. Burnham Soluble Iodine Co.

I-157 Nephro Sero. 4-page folder. California Endocrine Foundation Laboratories.

I-158 Abscess Sero. 4-page folder. California Endocrine Foundation Laboratories.

I-159 Shock Sero. 4-page folder. California Endocrine Foundation Laboratories.

I-160 Clinical Reports on Cito. 8-page booklet by Chlorine Products Co.

I-161 Lipoiodine "Ciba." 8-page booklet. Ciba Company.

I-162 Photomicrographic Camera. Bulletin No. 308. Eimer & Amend.

I-164 Interrupterless X-Ray Transformer, Type 2B. 16-page booklet. H. G. Fischer & Co.

I-165 Adrenal Support, by Dr. Henry R. Harrower. 16-page booklet. The Harrower Laboratory.

I-166 "Horlick's" Malted Milk; X-Ray Uses. 16-page booklet. Horlick's Malted Milk Co.

I-167 Obstetrical Blade. 4-page folder. Huston Brothers.

I-168 Effect of Intravenous Injections of Hexamethylenamin, by Drs. Bernhard Friedlaender and R. L. Cowen. Intravenous Products Co. of America.

I-169 Six Rules for Making Better Coffee. 4-page folder. Joint Coffee Trade Publicity Committee.

I-170 Diet for the Sick. 8-page booklet. Mellin's Food Co.

I-171 Antithyroidin for the Treatment of Exophthalmic Goiter. 6-page folder. Merck & Co.

I-172 Phyllosan in Anemia, Chlorosis and Wasting Diseases. 4-page booklet. Merck & Co.

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I-184 Bucky Diaphragm Table, Bulletin No. 246. Victor X-Ray Corp.

I-185 High Frequency Apparatus, Model "Wantz." Bulletin No. 221. Victor X-Ray Corp.